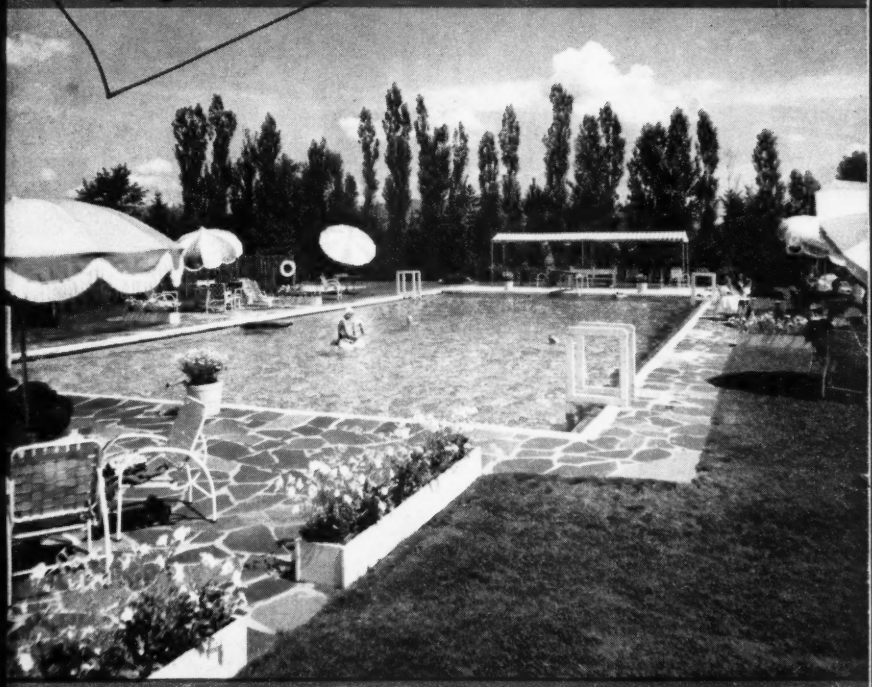
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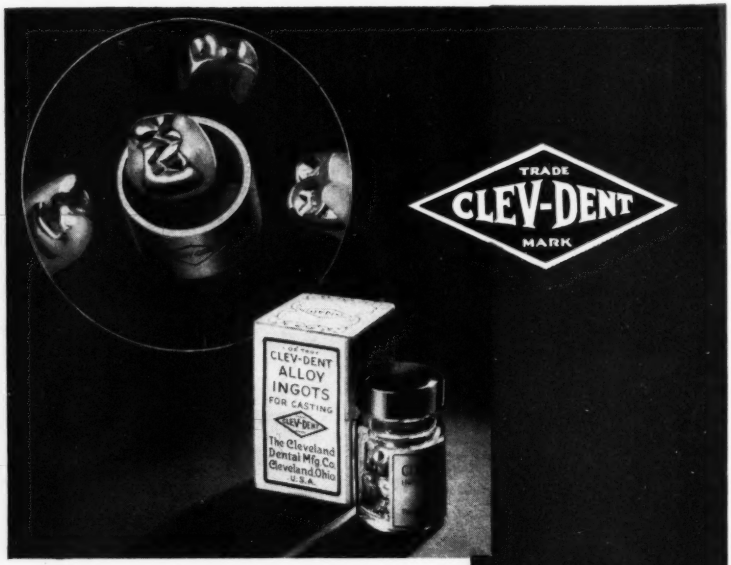
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In this issue:

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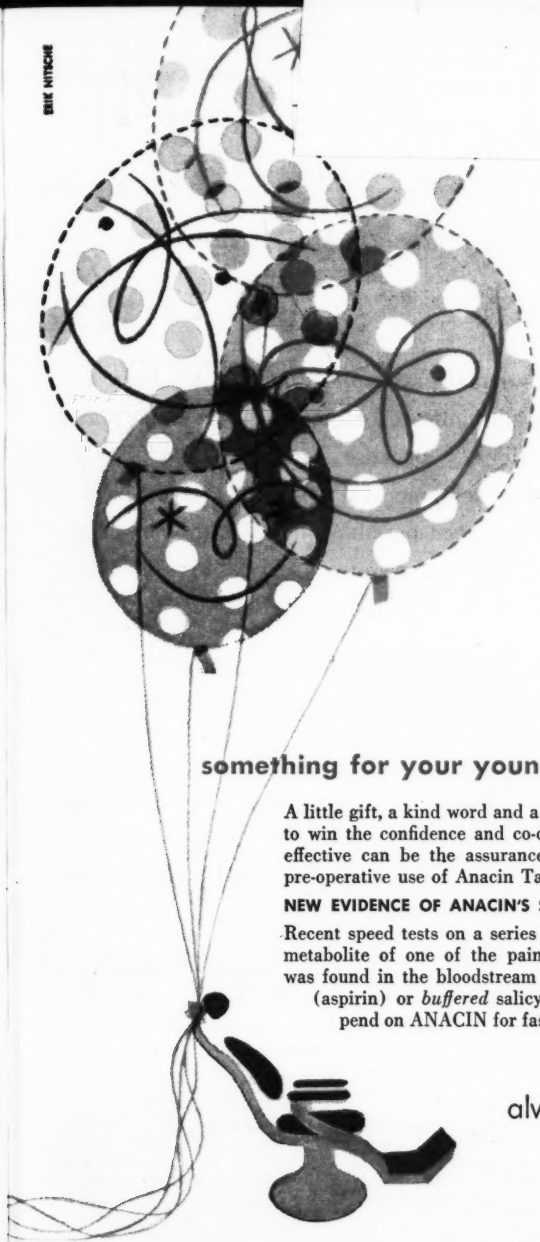
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1. Winter, L., Jr., and Van Gaasbeek, B.: New York State Dent. J. 18:119 (March) 1952.
2. Pollock, S. L., and Archer, W. H.: Pennsylvania Dent. J. 20:10 (March) 1953.
3. Kurzrock, A. H.: J. New Jersey Dent. Soc. 24:49 (April) 1953.

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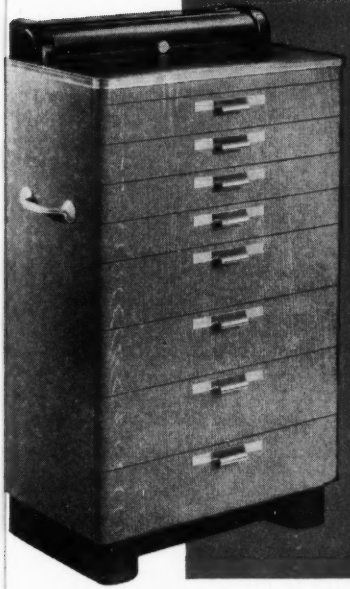
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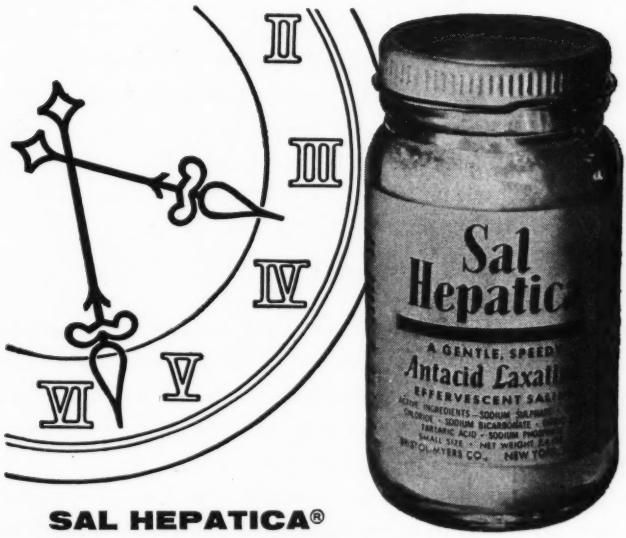
Mark Twain

IF YOU WERE TO ASK, "Who is your favorite author?" most folks would tell you the name of someone of at least fairly recent vintage. But some other folks wouldn't. Perhaps a surprising number of us would answer "Mark Twain!"

Mark Twain has been dead for 45 years. But he still lives in countless minds and hearts and quite likely always will. If you were to ask some of us who love Mark Twain *why* we love him, you would most certainly get a variety of answers. Because the man who started life as Samuel Clemens had so many appealing qualities.

People who don't know Mark Twain think of him as a humorist. And he was. But he was so much more than that—although he was the grand master of humor. And in the opinion of many of us his humor has not been matched by anyone who has since appeared on the literary horizon. Some of his classic tales are still delighting Mark's old friends. And delighting new friends, too, when they join the ranks of his worshippers.

Master of humor though he was, he had also another gift: he



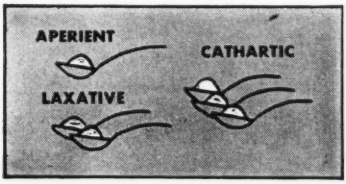
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References:

1. The Physiological Basis of Medical Practice, 1945, p. 486.
2. New England J. Med. 235:80, July 18, 1946.

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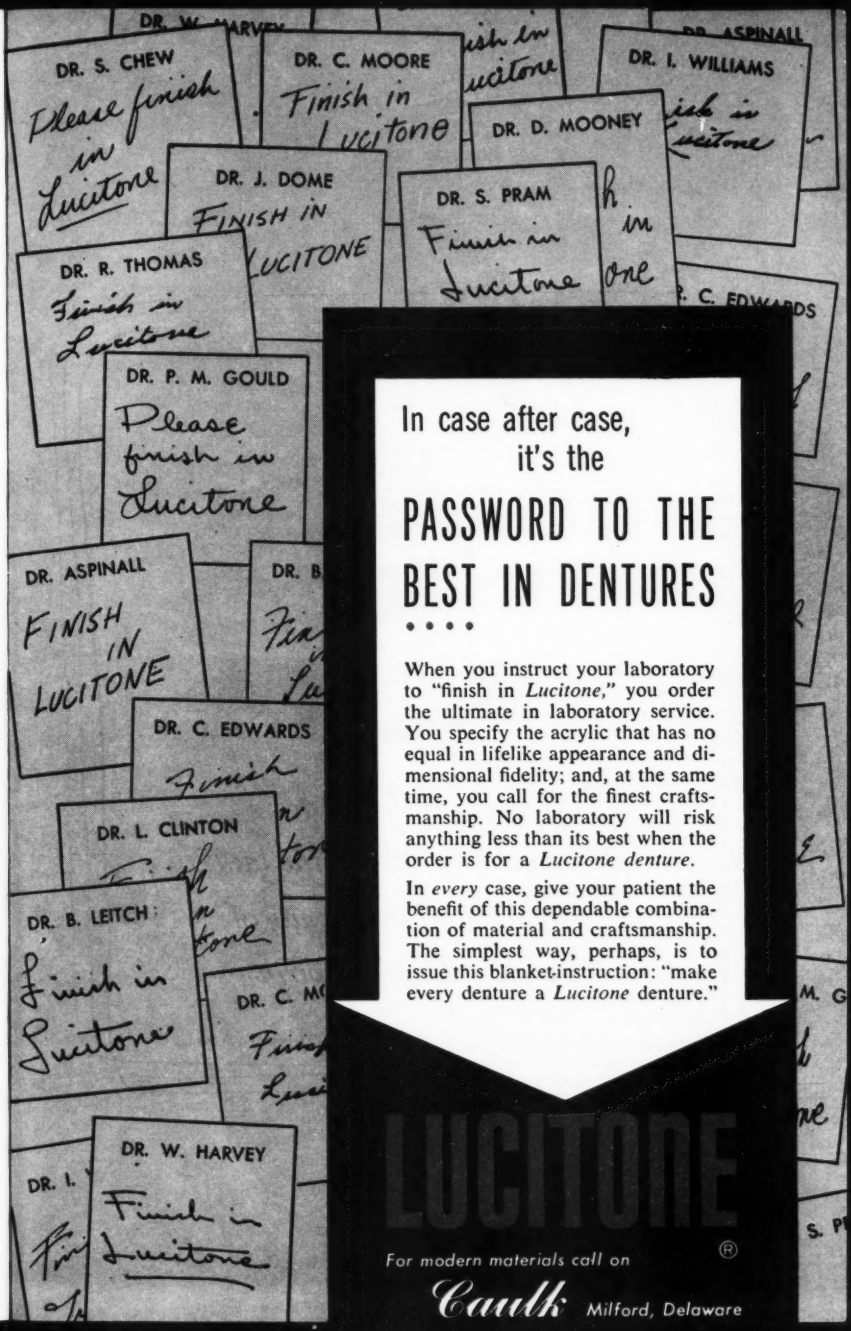
could move his readers to tears—a somehow soul-satisfying experience which leads one to return again and again to the magic paragraphs in, for example, "A Connecticut Yankee in King Arthur's Court." Visit the small-pox hut with the Yankee and King Arthur and you, too, will find yourself returning to repeat the experience. And each time you will be as deeply touched. Since boyhood, I have read "A Connecticut Yankee" at least twenty times. So I know.

Every facet of Mark Twain's creative genius is found, too, in "Huckleberry Finn." That's another book to read again and again, as the traveling companion of Huck himself and his Negro friend Jim. You don't just watch them proceed on their leisurely journey: you travel with them. You make it a group of three in the snug comfort of the cave on the island, safe from the lashing storm. You laze with them on the raft as they float down the Mississippi.

How many authors lure readers back into the same pages time after time? Not many, perhaps. It must take great genius to do that. Likely it takes more than genius, much more than a skillful pen, more than facility with words: a deep, a very deep, understanding of people, an abiding interest in people, curiosity about them that is unquenchable.

Mark Twain always said he didn't think much of the human race. Representatives of the race often infuriated him. He had little faith in the decent intentions of the race as a race. But he loved lots of the people in it, was patiently sympathetic with them, shared their sorrows and their joy.

Perhaps because he himself many times was grief-stricken he could understand others' grief. And one needs to understand grief to understand joy.


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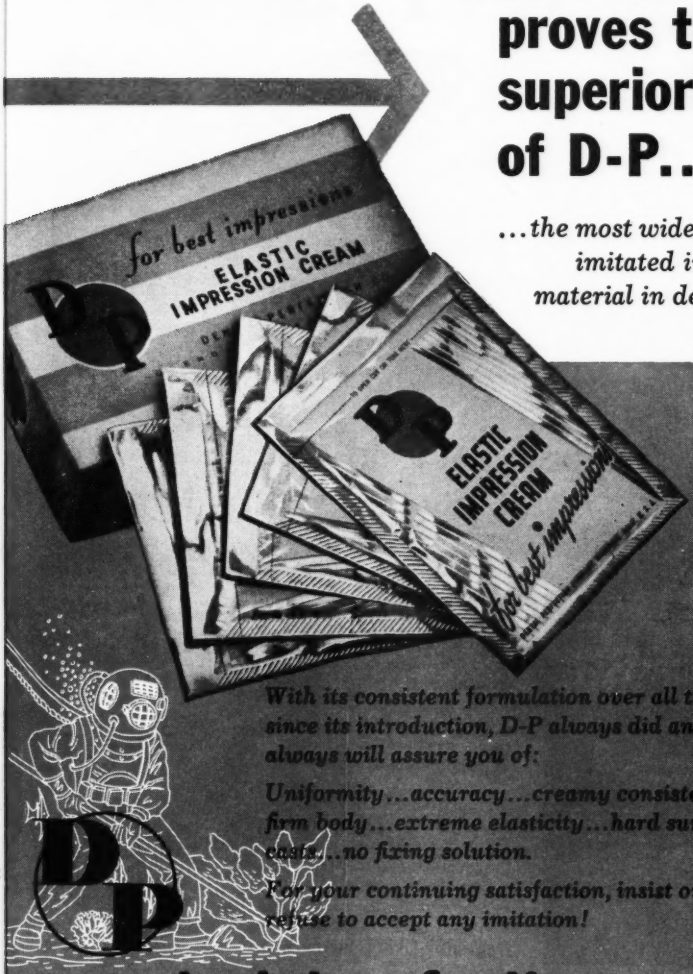
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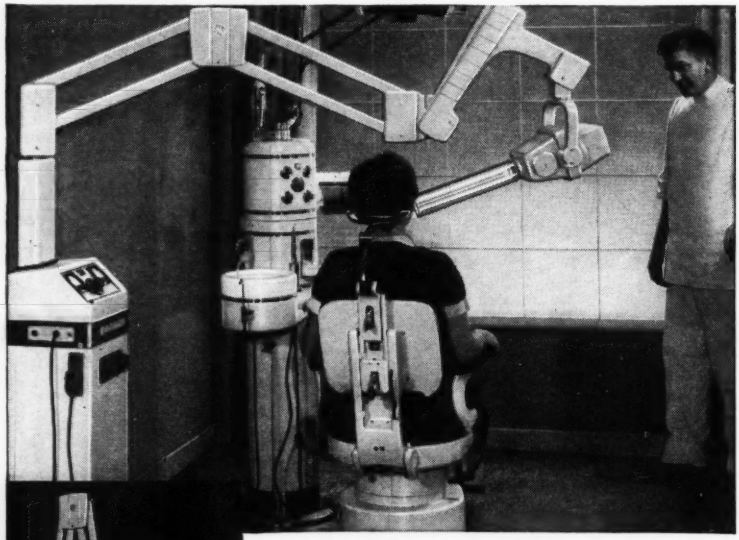
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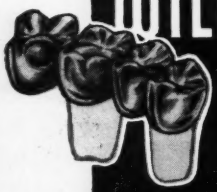
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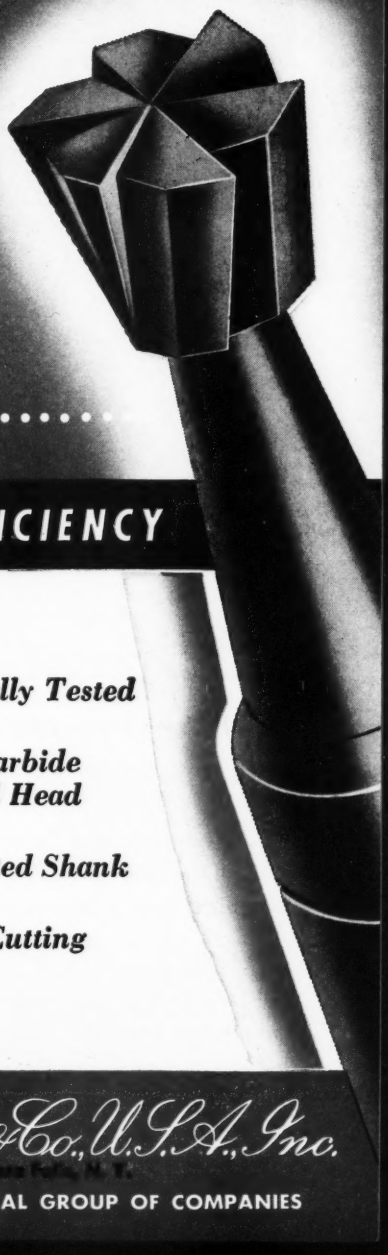
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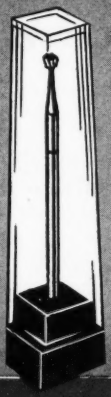
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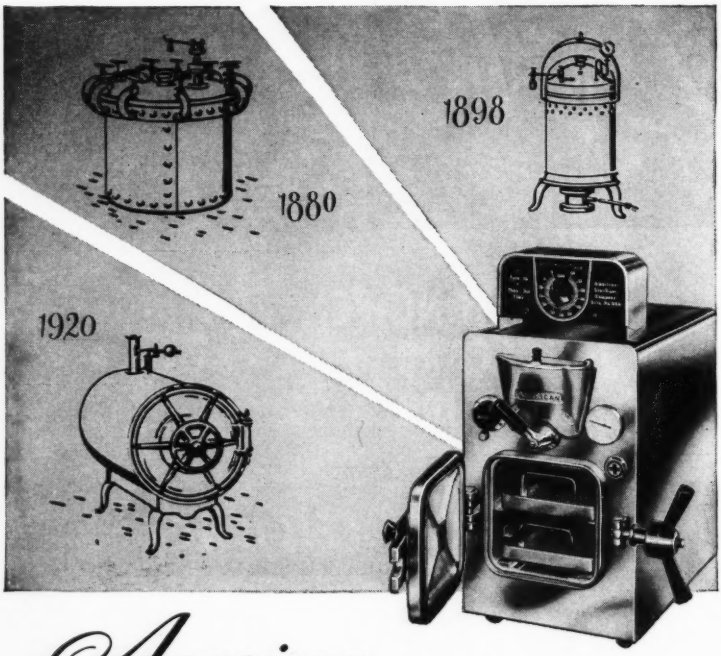


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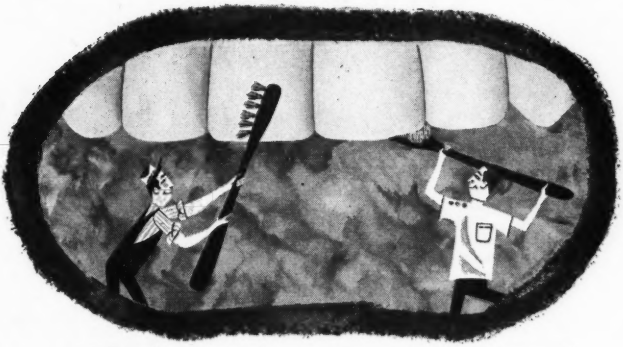
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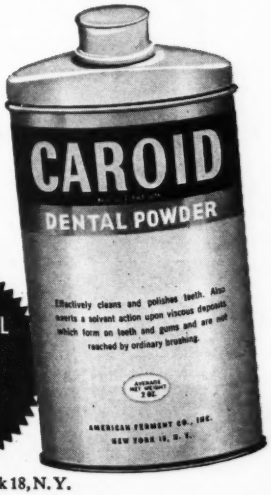
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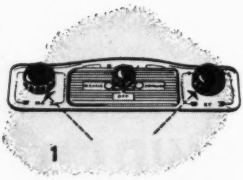
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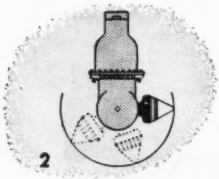
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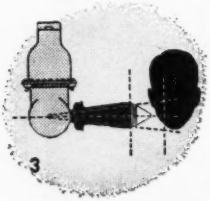


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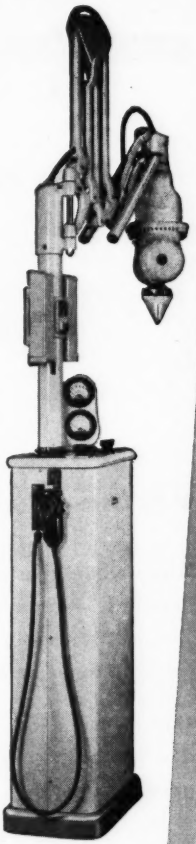

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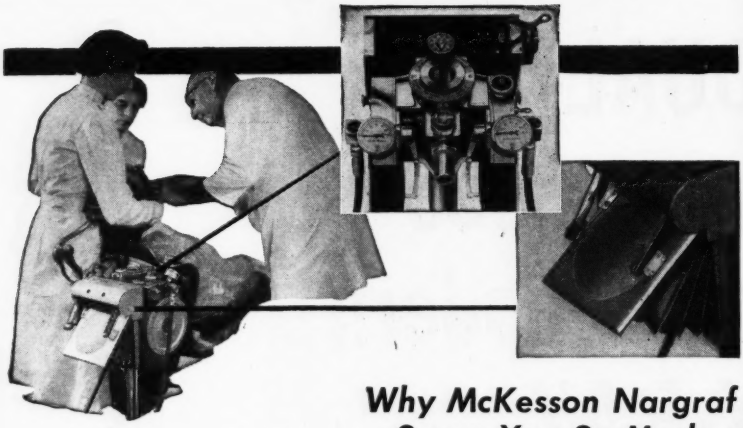
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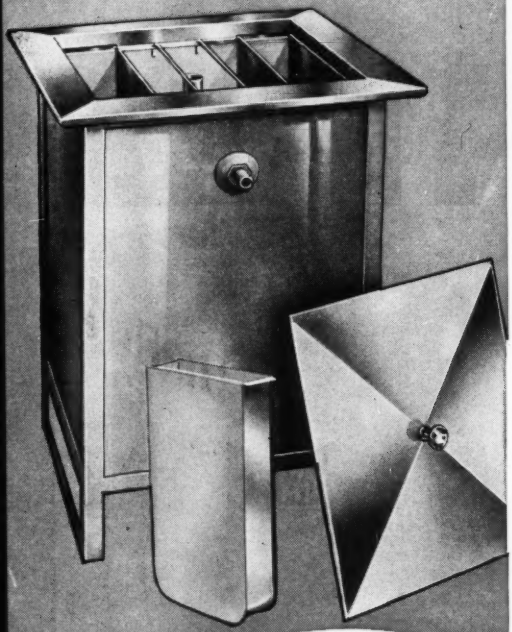
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References: 1. Report in press. 2. Brit. M. J. 1:1223 (May 29) 1954.

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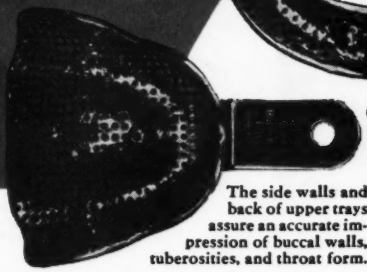
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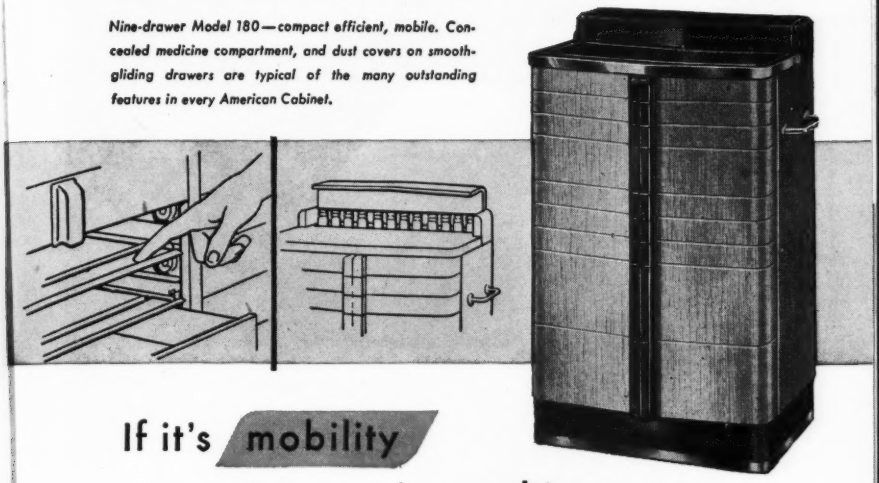
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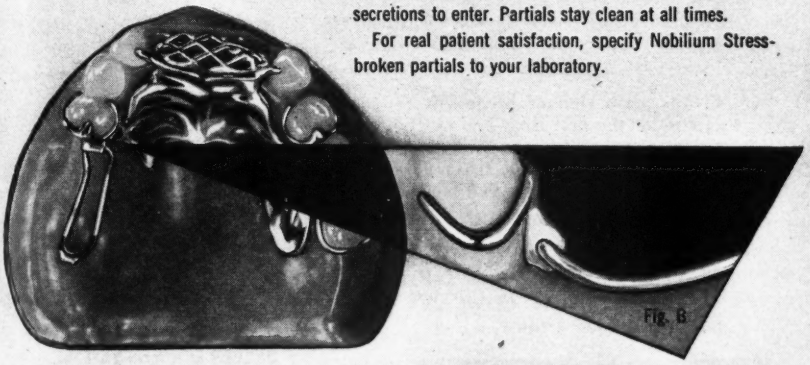


Fig. B

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*J.A.Ph.A 36:385, 1947
**J.A.Ph.A 38:258, 1949

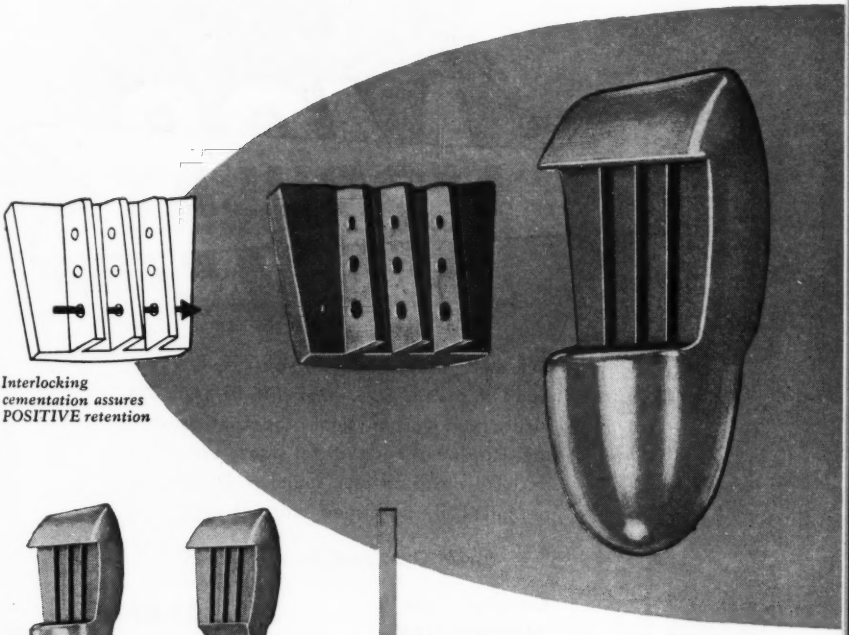


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EDWARD J. RYAN
B.S., D.D.S.

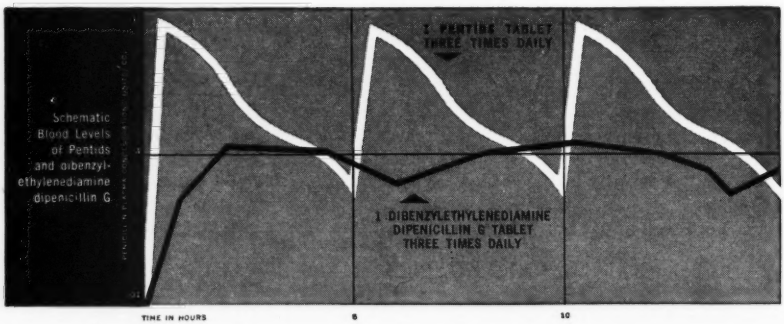
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Picture of the Month



DOCTOR T. Waldo Morgan, dentist of Denham Springs, Louisiana, is pictured on the steps of the State Capitol at Baton Rouge with Governor Robert Kennon (left), who had just presented him with a Bible for his having been selected by the Baton Rouge Ministerial Association as the "outstanding public official who most nearly practiced the Christian ideal in carrying out his public duties." Doctor Morgan has been a member of the Town Council, has worked untiringly for a city sewerage system, better street lighting, gas and water lines; he has been active as a Boy Scout executive, and has served with distinction as chairman of the official board of Denham's First Methodist Church.

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The Dentist Sees Deficiency Diseases

BY LUCIUS W. JOHNSON, D.D.S., M.D.

You are in the unique position of being able to detect telltale symptoms of deficiency diseases.

IN THE past three decades the public has been lulled into complacency by a number of articles in general magazines that told about the conquest of the nutritional deficiency diseases.

Scurvy, rickets, pellagra, beriberi, ariboflavinosis, pernicious anemia; all are but dim shadows from an unsavory past and have lost their menace. That is, unless you are critical of what you read, and inclined to look below the surface. But if you look more closely, you will find that, like the song popular a few years ago, "It Ain't Necessarily So."

The fact is that several of these one-time champion killers are still with us, are even widespread. No longer do they slay their millions, or even thousands of unhappy victims, as they did for centuries. They persist in mild, chronic forms that are spoken of as "subclinical." Carefully-controlled surveys of infants, school children, expectant mothers, factory workers and older people, have revealed the presence of subclinical deficiency states in a high percentage of the public.

What makes them important to the dentist is that the signs of the subclinical forms are often best seen in and about the mouth. The physician is handicapped by decrees of fashion that effectively conceal the symptoms he once observed for the early evidences of the nutritional deficiencies. The margins of the eyelids, the mucous borders of the lips, the fingernails, and the tissues of the cheeks are now hidden beneath opaque layers of mascara, lipstick, nail polish, powder and rouge. But the dentist can still see the tissues in the

raw and read their message without camouflage.

In the past, it was a dead heat between the dentist and the physician, which would be responsible for first detecting the deficiency states. Today the finger points firmly at the dentist.

The current danger of these maladies is not that they threaten death, but that they take away all enjoyment of life. Their victims exist on a low level of mental and physical vigor. All ages, from infants to great grandfathers, are subject to the danger. The dentist who detects the patient's condition, brings it to the notice of the physician, and collaborates in restoring the victim to vigorous health, will not only earn the good will of the patient, but will display admirably the value of cooperation between the two professions.

Let us put these vicious public enemies in the line-up, review their criminal records, and see how great a menace they are.

Niacin Deficiency: In its extreme and chronic form, it is known as pellagra or black tongue. Formerly, it was widespread in the tropics and in our southern states. In combination with the hookworm, it produced that ambitionless human character known as the "cracker." Tourists in certain parts of the South a generation ago were sure to be regaled with the "cracker" story. It went like this.

"What is a cracker like? Look over there, across the fields. See that dark object that might be either a man or the stump of a tree. Watch it for an hour. If it moves, it's a tree stump. If it doesn't move, it's a cracker."

Working with pellagra in Puerto Rico, Joseph Goldberger proved its real nature—a deficiency of niacin. In its severe form it has been pretty well eliminated in our country. The diagnostic four d's—diarrhea, dermatitis, dementia and death—are rarely seen. But the mild form, displaying a chronic glossitis and stomatitis, is still common in certain localities.

It is most severe in the spring of the year, with increasing sunlight. The tongue is bright red at the tip and sides. "My mouth is so sore I can't eat," is a common complaint. In the later stages, there may be atrophy of the papillae, so that the tongue becomes smooth and shiny. The patient is usually apathetic, ambitionless, low in mental and physical ability.

Thiamin Deficiency: This malady, in the form of beriberi, was prevalent among men of our armed forces, who as prisoners of war, were subjected to the starvation treatment. In our country, it is found mostly among the poor, the ignorant and the alcoholic.

A generation or so ago there was a delusion prevalent that white people in the tropics should not eat proteids. So beriberi was common among them, affecting especially those who substituted alco-

hol for the proteids. A small but vocal group has contended that meat is a harmful food. It has been asserted that animal proteids cause heart disease, high blood pressure, and damage to the kidneys. To controvert this idea, Vilhjalmur Stefansson and Karsten Andersen ate nothing but meat for a year, while closely supervised by Doctor Eugene F. Du Bois, professor of physiology at Cornell University. At the end of the year, they were found to be in at least as good health as when they started the experiment. Those who try to get along without animal proteids often are on the verge of serious thiamin deficiency.

In its mild form, it causes troublesome neuritic pains and low-grade digestive disturbances. In the mouth, the gingivae are bright pink and swollen; the tongue is edematous, with swelling of the fungiform papillae.

Riboflavin Deficiency: This is often associated with niacin deficiency in pellagra. In fact, most of the deficiency states are multiple, with more than one element lacking. The picture is seldom a clear one, of a single deficiency.

Riboflavin deficiency causes stomatitis and glossitis, with fissures at the angles of the mouth. Shallow ulcers and crusts on the lips are likely to bleed easily. The tongue is purplish red and the gingival margins are painful.

Ascorbic Acid Deficiency: What malady has killed millions of people and is still with us, though the means of preventing and curing it were known before the Christian era? You guessed it—scurvy. It killed a million men in the English Navy alone. Vergil, the Roman poet (70-19 B.C.), told how it could be cured with apples. Sir Richard Hawkins, who was the favorite merchant-explorer-pirate of Queen Elizabeth I, said in 1593 that he had known ten thousand seamen to die of scurvy. In 1795, the daily use of lime juice in vessels of the English Navy was made mandatory. This earned for its men the derisive nickname of limeys or lime juicers, but it banished the scurvy.

Today, scurvy exists in a mild form in infants and old people. Mothers may ignore the importance of citrus juices in the baby's diet, or they may use preparations which have lost their vitamin content by oxidation. Older people may adopt the theories of food faddists who scoff at the vitamin idea.

In the mouth, the gingivae are likely to be affected only in those with teeth. The soft tissues are swollen, purple, boggy, and bleed easily. The patients are weak, listless and discouraged. They bruise easily and may have hemorrhages in the skin and muscles.

It is seldom desirable for the dentist to pursue his observations of nutritional deficiencies to a definite diagnosis. One reason for this is that the mouth lesions are

rarely clear-cut and typical enough to provide a diagnostic basis. Another reason is that the deficiencies are often multiple. Usually it is better to refer the patient to his physician for a complete nutritional survey, so that the dentist and physician may collaborate.

The great danger of the chronic, subclinical forms of nutritional deficiencies is that they do permanent damage to the cells of the body. They lower the levels of mental and physical ability and take most of the enjoyment out of life. Most important of their evil effects is that they reduce the patient's chances of recovering from severe infections or major surgery. Several of them show their first warning signals in the mouth.

It is often affirmed that one of the major factors in extending the life span of mankind is the protection given us by the dentist. To detect nutritional deficiencies and to aid in correcting them is one of the noblest services that the dentist can perform.

3414 *Freeman Street*
San Diego 6, *California*

HOW MIDDLECOFF DID IT

WHY DID Doctor Cary Middlecoff, a dentist who learned his profession at the Universities of Tennessee and Mississippi, abandon dentistry for the much more competitive field of professional golf? Particularly when his dad was a dentist before him?

"I developed an ulcer on my right eye," explained Cary. "The eye specialist told me that if I stuck to dentistry, I'd have to wear glasses and be sure never to strain the eye, because I might lose the sight completely. Then he said: 'Is there anything else you could do to earn a living?' I told him there was golf, and he said that outdoor life might strengthen my eye. That's the way it happened."

By inheritance and training, Cary favors the scientific approach. "A couple of times, I theorized about golf so much that I almost wrecked my game," he tells you. "I was always looking for a formula for hitting the ball and for putting. This year, I think I found it." His new hitting form mula stresses the position of the right elbow on the backswing, a position that keeps the right elbow directly facing the ground, throughout the backswing and the start of the downswing. His round of 65 in the Masters, which spreadeagled the field, indicates that he found something valuable.
—ED SULLIVAN, *Chicago Tribune-News Syndicate.*



The Curse of Cut-Price Dentistry

BY HAROLD GLUCK, Ph.D.

THE YOUNG wife of the dentist was having a glorious time in this far-away vacation land. She picked up a vase and asked the price.

"One hundred sequistas," the proprietor of the small shop informed her.

"Too much," she snapped back. "I'll give you sixty sequistas for it."

"That is an insult to the honor of my family," retorted the proprietor. "Make it ninety sequistas and you can have it."

"Seventy," countered the young wife.

"Eighty," was the answer of the proprietor.

The charming woman started for the door when she heard the words:

"In this world a compromise is good. We split the difference. Take the vase for seventy-five sequistas. And believe me, I am losing money. Business is bad just now."

What can you do to satisfy the patient who is accustomed to shopping around for the best price?

The sale was made and the wife returned to the hotel to show her husband her latest acquisition.

"Quite a bargain," she informed him. "I would gladly have paid ninety-five sequistas for it. But I got it for seventy-five."

At that same moment, the proprietor of the shop was telling some news to his wife.

"Sold that vase for seventy-five sequistas. Not bad, eh! I would have parted with it for fifty sequistas."

For many years, and right up to the present, a lot of business has been done and is taking place under what is best described as "bargaining." The price of the product sold is somewhere between the maximum price the buyer will pay

and the minimum price the seller will take. Sometimes the prospective buyer is even informed that the named price is merely a starting point for discussion. If you ever have tried to purchase real estate, then you may have been told, "My client is asking this sum. Perhaps we can do a bit better." Or if you have traveled abroad and read the various guide books, you may have come across something like this: "The sellers in the market place enjoy the haggling over the sale. Never pay the first price asked."

In a competitive market where similar products are offered and the supply is greater than the demand, price cutting will start. And cut-throat competition can be disastrous. But should the prospective purchaser look at the various items and notice the price of each is the same, he may suspect some kind of an understanding among the sellers to fix the price. Price fixing has its adherents and its opponents. As I write these words, I am watching in my home town the efforts of several "discount" houses to fight the price fixing of goods, which is legal under our state statute.

We may go back to the husband of that young wife who bought the vase. Remember him? He happens to be a dentist. Would he want to go through a similar bargain "deal" with a patient who needs an upper denture? Especially if the patient has "shopped" around town and visited three other dentists.

Price Shopping

The dentists with whom I have come in contact do feel that the ideas of "price shopping" and "bargaining" are definitely detrimental to the best interests of the dental profession. As one dentist phrased it:

"I am a professional man with a definite ethical code to be followed. In what I do, I must consider first the service I give to a patient and see that it is for his interest in dental health. I am not selling a product in the market place in competition with other sellers. To be forced into such a situation would necessitate considering my own interests instead of the patient's."

From a letter written to me by an esteemed member of the dental profession, I quote the following:

"In my forty years of practice, I have made many observations pertaining to dental practice. I have found that about 50 per cent of the people who go to a dentist, don't care if his office coat is spotless, or if he needs a shave, or if his fingernails are clean, or if there is dust on the window sills. Neither do they care if he picks up a mouth mirror from the bracket table getting germs on his fingers, and they do not notice either whether the impression trays are sterile.

"This 50 per cent don't give a

continental about their dentist's ability and capability of turning out high-class workmanship. Neither do they consider the maintenance of a well-equipped office, staffed by trained assistants.

"This 50 per cent is interested in one thing only, 'Price!' And a *Cheap Price* at that! They inquire, 'Where can I get it done the cheapest?' "

What is the answer? That is what one dentist asked me, but I do not think it is within my province to attempt a solution to the situation. What I shall do is to present some data for your consideration. The solution, whatever be its nature, is one that should be within the hands of the members of the dental profession.

Price fixing is an old idea. Turn back the pages of history to the days of the trade guilds. Whether they were composed of spur makers, bakers, barbers, or shoemakers, it was a long, tough task for a member to get to the top. One had to be an apprentice, then a journeyman, and if he were good enough, a master workman. The guild regulated the way the goods were made, and also the price charged to the public. Men talked about a "just price," and the idea is still with us.

Price fixing has also been imposed by government authority. For recent examples, one need but turn back to the events of World War II, when ceiling prices were established on many products.

Price fixing is also possible in a legal manner in such states which have statutes regulating the situation. The manufacturer of a given item can control the price charged by the retailer and insist it be part of the contract.

What the dentist offers primarily to his patient is a service. That service consists of skills, techniques, methods, knowledge, and abilities. The dentist has to diagnose a given situation and suggest what is best for his patient. In regard to the concept of a service, we have state and federal laws regulating rates charged by public utilities. Water supply, gas and electricity, telephone, and means of transportation, are vital for the public *interest*. The rate charged is one, which is designed, at least theoretically, to give a fair return on the capital invested in the enterprise. Or if you want to word it differently, there is the idea of a "just price" to be charged. There may be a dispute over the rate suggested: the public utility claims the rate will not give a fair return on the investment, while the representative of the public claims the rate is exorbitant.

Price Fixing

If the members of the dental profession want to stop price cutting as a detriment to the best interests of the dental profession and the public, then you must have price fixing in one form or another. You "can't" have your cake

and eat it too. There may be the objection that price fixing will bring with it a host of evils and problems. Then the answer is to weigh the advantages and disadvantages on a scale and see which outweighs the other.

All considerations should be done without emotion clouding the brain cells. It is necessary to be consistent. You cannot say in one breath:

"Each dentist is an individual whose services cannot be compared with those of another competing dentist in terms of price.

"Disgusting to have that dentist down the street cut his prices. Charges a dollar less than I do for an amalgam filling."

For if you are going to have any method of price fixing, it can be done only if the services of a group of dentists can be compared and then "standardized." If you at any time in your practice have done work for certain agencies, you have seen such a standardized scale of "rates" for work done.

I have not overlooked the possibility of educating the public to the idea that shopping around for the best attainable "price" for dental service is not sound. True, the dentist himself can explain what goes into the fee he wishes to charge, the individual service that must be given, and why one cannot compare fees. The educator can also do his share in the school.

But how are you going to get the person who shops for bargains and cut prices in merchandise to distinguish between the market place and the dental chair? "Cut out the baloney, Doc, and cut the price," might be a shock to you. But the fellow in the chair saved $57 by shopping around for his television set. Same set, too. All your logic and patience may be wasted on him after his experience in the market place.

One thing is certain: no handful of men who call themselves dentists have any right, morally or legally, to take such action as will endanger the standing of the profession and the best interests of the dental health of people. A Thursday special: "Two teeth filled for the price of one," would be a nightmare.

Under our American way, discussion is good. We need more of it on this subject, so that when a solution is suggested, it will be sound and in our tradition.

2939 *Grand Concourse*
Bronx 68, *New York*

TOOTH IS GONE, BUT SHE'S WISER

A TRIP to the dentist resulted in the *Buffalo Evening News* getting an on-the-spot account of a double shooting.

Chief copy girl, Jeanne Le-Page Ray, had just strolled to the street from her dentist's office, where she had a tooth extracted, when the bullets started flying across the street from her. Jeanne dashed to a phone, alerted the city desk, and helped fill in some of the details.—*Classified Clinic.*



Your Job and Your Children

BY STUART COVINGTON

A dentist's child needs certain explanations of his father's services at the office, if he is to have a happy childhood free from emotional distress.

"YOUR father hurts people," says the freckled lad. "He hurt my daddy. He stuck a big, long needle in him!" And with that he proceeds to tell your son what a fiend he has for a father.

"My mother got sick after she went to your dad's office," your daughter hears from a schoolmate. "I heard her telling what he did to her. Does he do those things to you? He must be real bad."

While such indictments of the dental profession are probably not prevalent among the young fry, there are undoubtedly times when the dentist's children receive from their associates considerable misinformation concerning the character and occupation of their father. Since experiences in the dental chair are of necessity sometimes unpleasant, and since parents and visitors sometimes tend to exaggerate before children the unavoidable discomforts of restorations and difficult extractions, the younger generation is bound occasionally to acquire a misconception of the dentist's mission in life. Youthful curiosity being what it is, the dentist's child will inevitably be approached with questions about his father's habits.

However confident the dentist's child may be that his father is "a good guy," he probably will be disturbed by what he hears. He will be further upset by the fact that he is unable to offer an adequate defense for the accusations. His relationship with his companions may be adversely affected, and his feeling toward you, his dentist father, may change from affection and respect to one of guarded fear and gnawing doubts. Concepts implanted in the child's mind during his early youth can prove difficult to remove in later years, even when a child becomes

old enough to evaluate correctly his father's profession. Since the child may not disclose to his parents what he has heard, his father may never learn what effect his playmates remarks have had upon him.

Protect Your Children

To forestall the possibility of such unfortunate results, the dentist will do well to adopt some means of revealing to his children the true nature of his vocation and to dispel finally any stigma of cruelty or sadism under which he may have been placed. Naturally the methods used will depend largely upon the age and intelligence of the child, but here, in brief form, are several possible solutions which may be used effectively either singly or in combination.

Demonstration of Equipment: Show your child your most frequently used instruments, describing their use and how they operate. Explain that such things as drills and needles are used for the ultimate purpose of *relieving* pain rather than inducing it. Show the child that many dental instruments produce no pain at all.

Office Inspection: Although most youngsters pay a visit to their father's office once in a while, most of them have probably never been given an opportunity to closely inspect it. Permit children to examine thoroughly your facilities. Let them see that you are not harboring a "torture chamber" in which you perpetrate indignities on their friends' moms and dads, that there is no blood on the premises, and that, all in all, it is a pretty nice place after all. Better still, invite your children's friends to visit your office someday after hours, so you can meet each of them.

Explanation of Dental Care: Make a point of showing *why* patients' teeth need care. Explain, with the aid of charts, the damage cavities and abscesses can cause if not corrected, showing your child that his father, instead of dealing in pain and misery, actually enables persons to be relieved of discomfort, just as the family physician may cure Junior's stomachache. Explain as clearly as possible the many possible diseases which may develop from improper oral care.

Demonstration of Dental Technique: Using your wife or some other willing member of the family as a "patient," show your child an actual dental operation. Let him see that no harm comes to the patient and that there is no excessive pain involved. Emphasize that there are no "mysteries" about dentistry, that no black magic is involved; that a visit to the dentist is a perfectly normal experience undertaken by thousands of people every year. Take plenty of time during the demonstration, so that the child will be able to watch every move you made.

School Talks: If possible, arrange to talk on oral health to your child's class, explaining during the course of your discussion, a bit about the service of a dentist and how he performs it. Bear down on the dentist's efforts to relieve pain rather than to cause it. Illustrate the talk with charts and models; be as specific as possible. When your child's schoolmates see that you are an ordinary sort of fellow who likes boys and girls, they are likely to pay less attention to the reports of the terrors of your dental chair, which they hear at home.

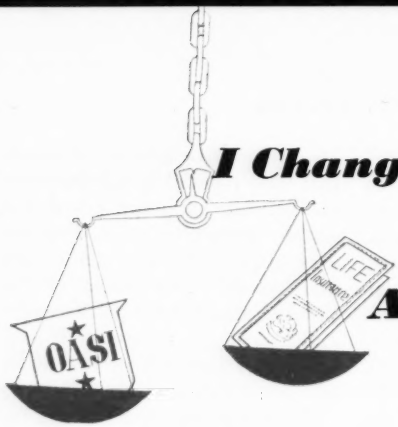
Encourage your children to ask questions about the kind of service you perform and attempt to answer these questions fully. Never give an evasive answer. Concede that some types of dental treatment are painful, but point out that a certain amount of pain is necessary to prevent more intense pain and possible impairment of the patient's health later on. Give the child plenty of ammunition with which to refute statements that his playmates may make.

Remember that a child's opinion of his father is one of the most important things in his life. Any belief that you are an unpleasant person may lead to unhappiness and serious emotional distress. Give him ample reason to be convinced that his father is not such a bad fellow after all.

1407 *College Street*
Columbus, Mississippi

LONGER LIFE—MORE SUFFERING

WE MUST admit one thing. There are more older people in the population today than there were in 1900, but this is due to the fact that fewer babies are dying. More of them are therefore living to older ages. This is due, not to the fact that modern babies are healthier or stronger than the 1850 babies, but that they are being protected against diphtheria and other killing contagious diseases by various methods. Unhygienic conditions used to kill babies by the millions through dysentery, for example. There is much evidence to show that older people today suffer far more from chronic diseases than did their old-time counterparts. They are weaker, they doctor more. They are operated on more. How many people are going around without their gall bladder? How many women have had their ovaries removed? They live and they suffer! They have only one or two years more of life, but how they suffer for it! The people were basically healthier in past centuries and lived longer, provided they were not knocked off in infancy or mowed down in later life by some contagious disease like diphtheria or tuberculosis.—J. I. RODALE, *Prevention Magazine.*



I Changed My Mind About OASI

BY WAYNE CLARK, D.D.S.

SEVERAL years ago I received a questionnaire mailed to members of the California State Dental Association in regard to OASI. I did not believe that the payments and coverage of OASI in its form at that time were enough to be worth while; consequently I voted against the program. The last Congress has increased the payments and coverage to such an extent that I think OASI should be re-evaluated by all active dentists. There is no doubt that OASI is here to stay. Each administration, whether Democratic or Republican, continues to improve and expand the program. Probably soon the payments and coverage will be sufficient for the average dentist after age 65. No doubt the next improvement will be a disability clause, whereby the insured person will receive immediate benefits after becoming disabled.

OASI is not intended to supplant any retirement plans a dentist may have, but to supplement his program. OASI operates on a non-profit basis, so the cost is small.

The following facts and statistics pertaining to OASI have been verified by the Office of the Social Security Administration, 2033 Shattuck Avenue, Berkeley, California, and much credit is due Mr. A. Zovickian and Mr. R. W. Haynes in the preparation of the following data regarding OASI.

Assuming that a dentist was included in the OASI program and that payments were made on the maximum of $4,200 each year and he is fully covered he would receive the following benefits at age 65: the dentist $108.50, his wife $54.30, a total of $162.80 per month for life. If he dies after age 65, his widow, when she passes 65, will receive $255 in cash and $81.40 per month for life; according to longevity statistics, his wife will outlive him eight years.

OASI is particularly attractive to a young dentist with children

California dentist gives factual comparison of benefits under Old-Age and Survivors Insurance and other life insurance programs.

under 18 years of age. If he dies before age 65, his widow will be paid $255 in cash and for herself and one child $162.80 per month, or $200 per month for herself and two children until they are 18 years of age.

If both parents die, the first child will receive $81.40 per month and each additional child $54.30 per month up to $200 while under 18 years of age.

OASI Versus Insurance

The accompanying figures show the total cost of OASI in different age groups until age 65 in comparison with a life insurance policy, which pays $160 a month for life at age 65. Rates were obtained from two leading companies. The cost varied somewhat and the lower figures were used.

The monthly payments on OASI are as follows:

	Monthly Payments
1955 to and including 1959	$10.50
1960 to and including 1964	13.13
1965 to and including 1969	15.75
1970 to and including 1974	18.38
1975 and thereafter	21.00

The monthly payments on the life insurance retirement policy paying $160 per month at age 65 for life are as follows:

Age	Monthly Payments
30	$56.20
35	68.98
40	86.75
50	158.67
60	Prohibitive

Part-time Employment

A dentist age 64 or older may become eligible for full OASI ben-

OASI VERSUS INSURANCE

Age	OASI	Life Insurance Retirement Policy
	Total Cost	Total Cost
30	$7,245.00	$23,604.00
35	5,985.00	24,830.40
40	4,725.00	26,024.00
50	2,362.50	28,560.00
60	630.00	Prohibitive
63	252.00	

efits by working two years and paying 3 per cent per year on the maximum of $4,200, or $252. On retiring at age 65, a dentist could earn up to $1200 per year by being gainfully employed and still receive OASI benefits.

Money received from dividends on stocks, rental property, annuities from life insurance policies, interest on savings and bonds, do not affect OASI benefits.

If a dentist wishes to continue practice after 65, he may do so, then retire when he wishes and receive benefits from the program. After age 72, he could receive benefits from OASI regardless of how much he earns by being gainfully employed.

To yield $160 per month income it will require an investment of $38,340 in American Telephone and Telegraph common stock at the current price of $180 per share, paying 5 per cent interest on the investment.

To yield an income of $160 per month, an investment of $76,680 would be required for bonds paying a return of 2½ per cent.

All of these are good investments and a dentist should consider them in his retirement plan.

There are many penniless dentists today who are depending on relatives and friends for a livelihood; others are helped by the relief fund of our American Dental Association and other charitable institutions.

At present, 72 dentists are receiving financial aid from the American Dental Association Relief Fund; 55 of these are age 65 or over. A number of the recipients receive some aid from their families or from welfare agencies, but the amount is insufficient to cover their needs and is supplemented by aid from the Relief Fund.

In 1954, of the 34 new applicants for ADA relief, 22 were over 65 years of age. Each year approximately 30 to 35 new applications are received.

In 1954, there were 101 renewal applications for ADA relief. This large number is accounted for by the fact that a number of recipients apply for two six-month grants in the same year.

The average number of recipients for ADA relief in 1954 was approximately 83 monthly. Each month a number of grants are terminated because of death or nonrenewal.

Unless the practicing dentist of today begins to make plans for retirement, dependence on the ADA Relief Fund will continue and increase year after year.

Many dentists in good health enjoy and are able to do good dentistry after age 65. Many others are not physically able to do dentistry that is a credit to the profession and would be glad to retire if they had a small monthly income; lacking this they

are forced to continue working.

The financially independent dentists who oppose OASI because they think they do not need the protection of the program, should consider its importance to their less fortunate brother practitioners, and, if for no other reason, should support OASI.

OASI is as safe as United States government bonds, and, if everything else fails, it will leave the dentist something for his old age. Our stocks, bonds and savings, are so readily available that there is the temptation to cash them for an investment that may prove a failure.

In 1953, our House of Delegates at the ADA Convention voted 312 against and 64 in favor of OASI. In 1954, the vote was 235 against and 152 in favor of the program.

A recent Ohio state poll endorsed OASI 8 to 5. New York State endorsed the program 7 to 1.

What You Can Do Now

If you are in favor of OASI, make plans for having the matter discussed at your dental society meeting. A representative of your local social security office will be glad to appear to supply additional information and answer questions.

Finally, let your wishes be known to your members of the House of Delegates, your two Senators and the Congressman of your district, or individually write to your Senators and Congressman.

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Berkeley 7, California

DOCTORS OR DENTISTS?

THE GENERAL public, newspapers, magazines, physicians, and dentists too, frequently use the phrase "doctors and dentists." If the word doctor is used as a synonym for physician, the inference is that among all of the people in all the various phases of learning, the physician alone has the capacity to qualify for the title "doctor." If the word dentist is used advisedly in the phrase "doctors and dentists," then it is the dentist who is specifically eliminated as not qualified for the title "doctor."

Undoubtedly, there are dentists who do not measure up to the exacting standards demanded by the title doctor; however, the same can also be said of our medical colleagues. In view of the ever-increasing use of the phrase "doctor or dentist," perhaps we in dentistry should put our collective souls under the microscope of truth and try to determine whether we are doctors of dentistry or merely dentists.—*The Bulletin of the Alabama Dental Association.*



What I Learned From Wilbur

BY ROBERT P. STICKLEY, D.D.S.*

IT TOOK me several weeks to recover from my last conversation with Wilbur. However, I decided if I were going to help him, I would have to put up with him. So I went to see him, thinking that perhaps I could give him some advice about managing his business.

I began by explaining to him how I ran my business, which, incidentally, turned out to be more difficult than I had expected. I realize, of course, that this was due to the fact Wilbur is so dense. After hearing me out, he quietly stated that he was conducting his affairs on a budget plan.

"Well!" I said. "Perhaps you can tell *me* how to run a business." Would you believe it, he started right in, and said that when he first began to practice and had good collections, he spent freely. When collections were bad, he either went in debt or made a note. He said that when large items came due, like insurance premiums or taxes, he nearly always had to make a note. As a consequence, he said, half the time he did not know what his financial status was. So he decided to adopt a budget system.

He gave me a copy of his budget system, which operates on a weekly basis, including the following:

1. Taxes
2. Insurance
3. Wife's allowance
4. Christmas savings
5. Church, contributions and charities
6. Secretary's salary
7. Supplies
8. Health
9. Special
10. Personal spending
11. Vacation fund
12. Retirement fund

To show you how rude Wilbur is, before I could say anything, he

*This is the second of a series of eight informal discussions of various aspects of practice management between two practitioners with divergent ideas on practice building and security.—The Editor.

Budgeting problems are discussed by two practitioners.

began explaining each item in this manner:

1. Taxes—he takes last year's figure from his tax report, divides it by fifty-two and sets up that figure in his weekly budget.

2. Insurance—he adds all types of insurance premiums and divides by fifty-two and sets up this figure in his weekly budget.

3. Wife's allowance—this includes all expenses in connection with running the home, and an item called "Extra" to take care of unexpected expenses. This item is discussed between them whenever possible and agreed upon before the money is spent.

4. Christmas savings—a weekly amount paid into a Christmas savings fund.

5. Church, contributions and charities—all of last year's contributions were noted from the tax return, and divided by fifty-two and placed in a weekly budget. This amount, of course, is subject to change as he sees fit.

6. Secretary's salary—a fixed weekly office expense.

7. Supplies—last year's supply bill furnished by the supply houses was added and divided by fifty-two. This was done to create a fund to level out the supply bill over the year.

8. Physician's fees—realizing that health insurance did not take care of all the physician's fees, a small amount is set up weekly to help take care of this item.

9. Special—for current general expenditure. From experience he knows that he will have a general current expenditure, and while admitting this is a tough one, he sets up a fixed sum. What he puts aside weekly on the estimate takes most of the headache out of this item. Wilbur claims that over a period of time he has been able to estimate the amount satisfactorily.

10. Personal spending money—no special amount is set up. A ticket is made for each withdrawal during the week and is set in the weekly budget.

11. Vacation fund—a weekly sum is budgeted. If too much, it is carried over in this fund. If not enough, it is at least a help in the vacation expense. If an expensive trip is planned ahead, the sum is increased to meet the demand.

12. Retirement fund—5 per cent of every gross dollar is taken out. The balance of the budget is predicated on a ninety-five cent dollar. This 5 per cent is regarded as a just and indisputable compensation for his efforts. It is invested carefully and regarded as a sacred trust to insure his retirement in reasonable comfort and dignity.

Budgeting is Easy

Well! I told Wilbur this juggling would drive me crazy. He replied that once set up, the operation was mostly the job of his secretary. He

merely supervised it. Also, he said there was nothing complicated about holding the weekly budget tickets until they were paid. The important and comforting fact was that all expenses were being accounted for weekly, and paid for as soon as the money was available. Frequently, he said, he was not able to pay the budget in full the last weeks of the month, but was able to catch up during the first weeks of the new month when collections were better. He said too that sometimes it was necessary to give certain items in the budget preference in payment over others, but with the budget before him at all times, this could be handled with no undue amount of confusion. I pointed out to Wilbur that he did not have his laboratory bill in his budget; he said that since he did not pay it weekly, he found it easier to try to pay it as a separate item by the tenth of the month.

You can see how evasive Wilbur is. What made me angry was that he just sat back and calmly told me that since he had his financial status before him at all times, he lived within his means. He said that when bills came due, he was ready for them, and, furthermore, he did not always have a note in the bank. And then, in that innocent way of his, he asked *me* how Mr. Jones, the teller at the note window of our bank, was getting along.

100 *Quinlan Street*
Lynchburg, Virginia

COMMENT ON FLUORIDES IN BRAZIL

"TODAY, in the United States, we are artificially fluoridating some of our water supply in the hope that it will prevent or greatly reduce tooth decay. Some of the results have been reported to be excellent. We should be interested, however, in a remote area in Brazil, located in northern Minas Gerais, where I found a large section of the populace with really dreadful teeth. Only a few people over the age of 15 have more than rotten front stubs in their mouths to chew with.

"Lack of fluorine in their drinking water? On the contrary. Knowing the territory was highly mineralized and contained many fluoride mines, I gathered samples of water and had them analyzed. Fluorine was high in all water examined!

"Elsewhere in Brazil, in areas where fluorine in the water is absent, I found whole communities with sensationally good teeth. The incidence of dental caries was lower than any reported in our country. Surely we need to investigate!"—EUGENE H. PAYNE, M.D., *This Week, New York Herald-Tribune.*

So You Know Something About DENTISTRY!



CXXIX

1. In the presence of a granuloma, the pulp of the tooth will be (a) absent, (b) vital, (c) non-vital.....

2. True or false? The curve of Spee is regarded as being correlated with the functional effort of the muscles of mastication .....

3. As a rule, which has the closer relationship to the maxillary sinus? (a) first bicuspid, (b) second bicuspid?.....

4. In the mandible, why is a high lingual frenum undesirable for a proper impression in denture construction?.....

5. The mandible is in a position of centric relation when the condyles are in their most distal (a) strained, (b) unstrained, position.....

6. Is epinephrine an efficient hemostatic agent when applied directly to small bleeding vessels? .....

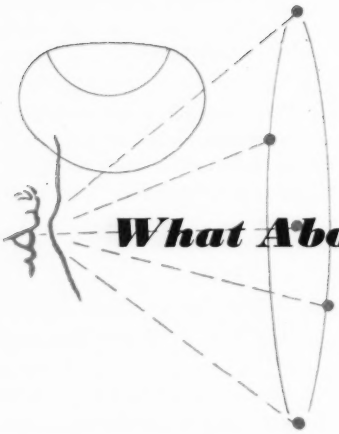
7. With growth and development, the facial bones increase in size at (a) a greater rate than, (b) the same rate as, (c) a lesser rate than, the cranium.....

8. With the ideal inlay technique, cement should be regarded as (a) a sealing, (b) a retentive, agent .....

9. True or false? In order to stimulate caries, any sugar solutions must be capable of diffusing into the adherent bacterial plaques on teeth.....

10. Incising of the gingivae is (a) seldom, (b) usually, indicated to facilitate the eruption of teeth.....

FOR CORRECT ANSWERS SEE PAGE 748



What About Your Eyes?

BY DONALD HERSH, B.S., M.S., O.D.

IN THE increasing complexity of our modern way of life, the dentist's work typifies the increased and specialized demands which have been placed on our visual mechanism. The seeing apparatus which served our ancestors for their gross visual undertakings of hunting and tilling the soil is the same seeing apparatus which the dentist calls upon for prolonged near-point concentration under artificial illumination. This is the visual mechanism which must serve the dentist when doing root-canal therapy, reading roentgenograms, or preparing the D.O. on an upper left eight. The demand for high efficiency, protracted seeing, is obviously great.

Clear vision is not the criterion which decides whether or not the dentist's eyes are responding to his visual demands adequately. The clarity with which the dentist is able to see and the efficiency of his overall seeing apparatus are rather distantly related phenomena. Actually, clear vision can be retained while focal imbalances, muscular imbalances, and a wide variety of neuro-muscular malfunctions, are present, as well as with many types of pathologic involvements. More often a low efficiency seeing situation will present rather vague and generalized symptoms, if any, and often clarity of vision is last to be affected. A dentist with poorly adapted near-point vision might well find that he will fatigue readily, or tend to draw back from the

If you feel eyestrain, you will want to try the eye exercises and special prescriptions described here.

operating field, or feel a vague desire to look up from his work frequently. He may develop a headache toward afternoon and feel as if his eyes are "strained." The symptomotology is most often vague and of a variable nature. One aspect of the problem, however, is constant. If the dentist is forced to use his eyes in this specialized manner while his visual apparatus is unequipped to operate comfortably, his overall efficiency will nose-dive, and additional nervous energy will be required to force his eyes to do their job. He will get, so to speak, less "miles to the gallon."

There are several devices which the average dentist may use to allay an otherwise abused visual mechanism. It is to be recommended that the dentist occasionally glance up from lengthy, close work, and direct his eyes to the distance for a moment to relax the ciliary muscle. At his leisure, he might rotate his eyes clockwise and counterclockwise to the limits of their rotational excursions. He might perform saccadic fixations by alternately directing his gaze from the primary straight position to various oblique directions of gaze, each time returning to the straight position. A large imaginary clockface of about two yards in diameter at a distance of approximately two yards is helpful in providing guideposts for these simple tonic-type exercises. To enhance ciliary ability, we occasionally make use of the accommodative rock technique, where the vision is "rocked" between a rather close object (for example, print at seven inches) and a distant object. An average of four seconds on each target is an adequate interval.

We must not, however, lose sight of the fact that the abilities and shortcomings of the near-point vision of the dentist can be determined only through a comprehensive near-point visual analysis. It is necessary to explore the abilities of the ciliary muscles and the extrinsic muscles, as well as to determine the proper balance between the two eyes. The examination must be conducted with an appreciation of the dentist's working distance in mind. This comprehensive analysis is the only way a proper evaluation of the near-point abilities can be made.

Presbyopia

Most dentists over 40 years of age, unless nearsighted, will find that a near-point spectacle prescription will be required to enable them to see clearly when performing any type of close work. The normal occurrence of presbyopia between ages 40 and 45 acts to decrease the focal abilities of the eyes, and some form of out-

side help is necessary. For these persons there are presently available many forms of lenses, which will restore their near-point vision. Inasmuch as a wide field of clear, near-point vision is desired, specialized, bifocal lenses are available with enlarged segments. These occupational bifocal lenses are designed to give the operator maximum vision when working in the mouth and still enable him to see clearly around his office.

Many men, however, utilize one bifocal prescription for both operative dental service and everyday use. This is not always the best mode of correction in that it is often more desirable to have an extra large bifocal segment situated higher in the body of the lens for dental operations. Also, many dentists use a closer working distance when doing dentistry than when reading. The strength of the lenses must be adjusted accordingly. When having his eyes examined, it would benefit the dentist to have actual measurements of his working and reading distances available for the examiner. He should also indicate the angle at which he holds his head when working in the mouth. These factors will aid the examiner in determining the strength and location of the bifocal segment. As you realize, the posture of the operator when performing dentistry may be quite different from his reading posture, and this figures markedly in the prescription of an adequate correction for both working and reading.

While the simple performance of everyday dentistry may be no more taxing than most physical occupations, the visual demands placed on the dentist's eyes are comparatively far out of proportion. While the dentist can follow a rather small regimen of visual hygiene, it remains for the examining optometrist to perform his analysis and apply correction in the light of the unusual visual demands of the dental office. The dentist can assist by presenting a clear picture to the examiner of the manner in which he uses his eyes throughout his working day. We will thus be best able to prescribe from a preventive as well as an occupational, corrective point of view.

856 *Grove Street*
Irvington, New Jersey

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.



Dentists in the NEWS

New York (New York) Times: A man who entered the office of Doctor Leonard Kaminsky at 315 West End Avenue, complaining of a toothache, walked out a few minutes later with jewelry and $130 in cash. He left the dentist, the dentist's wife, a family friend, a patient, and a cleaning woman, with their hands neatly tied by the dentist's own assistant at gunpoint. It was Doctor Kaminsky's first day in an office he had just acquired.

Albuquerque (New Mexico) Tribune: The two new members of the University of New Mexico board of regents are a former star athlete of the school, John F. Simms, and Doctor Ralph Lopez, a dentist of Santa Fe. The Governor sent the nominations to the State Senate, requesting that both be named for terms ending December 31, 1960.

Knoxville (Tennessee) Journal: Doctor Jack T. Breihan, Rock Springs, Wyoming dentist, has made an important niche for himself in the role of gun collector. Through history, he became interested in the hobby and began hunting up weapons once owned by the West's early gunmen, because of his proximity to the frontier areas where documentation was foolproof. Prize of Doctor Breihan's 100-gun collection is a .50-.70 Springfield rifle once owned by the famous mountain man, Jim Baker.

Houston (Texas) Chronicle: On the occasion of its 24th anniversary celebration, the Houston Dental Auxiliary honored Doctor Stella Risser Telfer, one of the group's charter members and the first woman to be named president of the Houston District Dental Society. The Auxiliary staged a "This Is Your Life" program about Doctor Risser, tracing her life from her birth in Lynn Grove, Indiana, through her schooling and professional activities. In her honor, the group presented $150 to the state memorial fund to help further the education of worthy dental assistants.

San Diego (California) Union: The sweepstakes award at the Camelia Society's eighth annual camelia show in San Diego went to Doctor R. W. Tellam, Ramona dentist, for the third successive year. Another dentist, Doctor E. Clark Hubbs of Glendale, a past president of the Pacific Camelia Society, won the other two top trophies at a show, which attracted more than 1,500 visitors on its opening day.

Boston (Massachusetts) Herald: Appointment of Doctor Lionel W. Bryer of Bloemfontein, Union of South Africa, and a former Rhodes scholar at Oxford, to a research fellowship in the Harvard School of Dental Medicine, has been announced by Dean Roy O. Greep. Doctor Bryer will continue his work on the endocrine glands and their effect on tooth eruption.

Portland (Maine) Press Herald: One of the five Americans to be awarded England's Order of the British Empire was Doctor John B. Ells, 64, of Bar Harbor, Maine. The awards were presented recently "in recognition of services in the cause of Anglo-American friendship and understanding" at the

British Embassy in Washington. Doctor Ells has been greeting American, British, Canadian, and French men-o'-war for thirty-five years. He goes out of his way to have ships land at Bar Harbor. The dentist's famous hospitality has contributed greatly to their willingness to dock at the resort town. Doctor Ells estimates that he has introduced more than 20,000 British naval officers and sailors to the famous Maine resort town.

Nashville (Tennessee) Banner: A former president of the American Dental Association, Doctor Oren A. Oliver, was appointed as representative from the ADA to the White House for ceremonies and a luncheon in April with President Eisenhower to start the campaign for Korean dental rehabilitation.

The nation-wide campaign is aimed at enlisting all dentists to aid in this rehabilitation of dental education and services, sponsored by the ADA and the American-Korean Foundation. Special dental memberships in the Foundation are available to dentists for $5, and larger contributions are also anticipated.

New York (New York) Journal American: Under the direction of Doctor Stanley Spiro, chief dental anesthesiologist, a special general anesthesia service has been inaugurated at the Jewish Chronic Disease Hospital, East 49th Street and Rutland Road.

This treatment is important in cerebral palsy, which affects muscular activities and causes the patient to make involuntary movements in the dental chair, according to Doctor Spiro. This is the first program in the city which includes the services of complete oral rehabilitation of the cerebral palsied child.

Cedar Rapids (Iowa) Gazette: Doctor George S. Easton, a member of the board since 1951, has been named the new chairman of the board of control of intercollegiate athletics at the State University of Iowa. Doctor Easton is a professor in the college of dentistry.

Chicago (Illinois) Daily News: One of the unexpected results of the Chicago Midwinter Meeting was a new song called "Black Orchid." The composer is Doctor Royce Swain of Omaha, Nebraska. He wrote the words while attending the meeting, and the prospects of the song becoming popular on radio and television are good. One song Doctor Swain composed while doing dentistry, TWICE AS MUCH, sold 500,000 copies.

Philadelphia (Pennsylvania) Bulletin: A legislative investigation of Laurelton State Village is being conducted under the direction of State Senator Albert R. Pechan. A Ford City dentist, he was named chairman of the joint legislative committee of eight members. The committee began its work by inspecting Laurelton, an institution for mentally defective women in Union County.

Des Moines (Iowa) Register: Admiral Daniel W. Ryan, former assistant chief of the Navy Bureau of Dentistry, has been appointed navy dental inspector of the West Coast. Navy dental officers of the Washington, D.C., area gave a farewell party in honor of Admiral and Mrs. Ryan before they left for their new post via New Orleans, Mexico, and San Diego, California.

St. Louis (Missouri) Post Dispatch: For the last ten years, Doctor Ernest W. Clegg has been broadcasting dental programs over radio station KFUO. In appreciation for his services, he was honored at a dinner given by the St. Louis Dental Society and presented with a scroll. Throughout his period of service, Doctor Clegg has not missed a Thursday afternoon appearance on the radio program.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

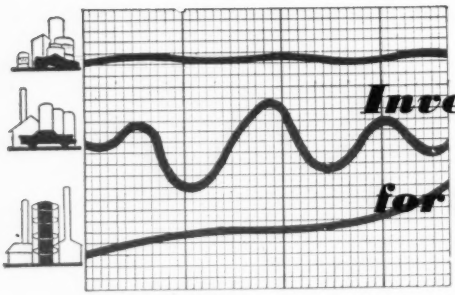
R. B. Moore, D.D.S., Box 237, Allerton, Iowa
Colonel William Perry, Rittenhouse Claridge, 18th & Walnut Streets, Philadelphia 3, Pennsylvania
Frank V. Faulhaber, 781 Woodward Avenue, Brooklyn 27, New York
D. H. Aitkenhead, 5130 Muir, San Diego, California
Hugh E. Thomas, Route 3, Madisonville, Tennessee
Samuel Ruiz, D.D.S., 801 Encino Place, Albuquerque, New Mexico
Mrs. Melvin M. Meilach, 7005 South Normal, Chicago, Illinois
Bea Burnett, 3713 Newhouse Street, Houston, Texas
Mrs. Ira Netser, North English, Route 1, Iowa
W. H. Griswold, 21 Summer Circle, Lynn, Massachusetts
W. L. Lynes, D.D.S., 6677 Delman Boulevard, St. Louis 5, Missouri
Mrs. Ursula Erickson, 8920 West 28th Street, Minneapolis 16, Minnesota
I. Landeen, 170 Main Street, Dexter, Maine
Gerald Westreich, 88-24 150th Street, Jamaica 35, New York
James E. MacDonald, The Earle Hotel, 111 South 10th Street, Philadelphia 7, Pennsylvania
Mrs. J. W. Ward, Carter Building, Franklin, Tennessee

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News,* we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be *acknowledged or returned.* When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

BASIC ELEMENTS OF LIVING

GREAT AND towering is the man who gains his sense of direction by the truth of his profession and lives by it within himself, and yet always looks with understanding and sensitivity to the impact of other persons about him. I do not intend to be melodramatic, but I say to you that human life is sacred and when, by the skill of your hands, you bring to pass changes of facial characteristics that, had the malocclusion continued, would have meant a warped, distorted personality, you have put your hand to the Hand of God. But a man must take care that the hand that is so capable is the hand that will remain strong; that the mind that is so alert is the mind that will always be open to the new truth; and that the spirit that must be so stable and mature will never be distorted by any of the aberrations of human behavior in himself or in others.—GEORGE D. HEATON, D.D., from *American Journal of Orthodontics.*



Investments for Dentists

BY J. F. HONOLD*

STABLE or income stocks are those that have greater stability of earning power and dividend payments than other issues throughout the business cycle. The classical example of this type is common stocks of public utility operating companies, and particularly those companies which are primarily suppliers to domestic users. Other consumer goods companies, such as those in the cigarette, food, beverage, and shoe industries, may be placed in this category. Stocks of companies in the insurance and banking fields may be included under "stable" issues. "Stable" or "income" stocks are not immune to market trends, but these stocks usually show relatively less weakness in terms of price and dividend income than in the case of more volatile industrial shares. Where income from investments is an important consideration, a security portfolio should have a broad representation of this class of common stocks even in a period of inflation.

Another grouping of common stocks is that commonly referred to as "cyclical." Common stocks in this grouping are generally most sensitive to business developments. Prices of these stocks swing rather widely in the course of a business cycle. Industries in this category are:

A. Durable goods or heavy industries—iron, steel, machinery, heavy electrical equipment, railroad equipment.

B. Commodity industries—copper, lead, zinc, coal.

C. Consumer durable goods—automobiles and auto parts, household equipment.

D. Railroad industry.

The profit potentialities of cyclical stocks attract many investors. Unfortunately, this attraction generally is aroused only after a long

*Reprinted from *Pennsylvania Dental Journal.*

Broadly speaking, there are three types of common stocks —stable, cyclical, and growth.

and protracted rise in the business cycle and usually close to the peak in earning power and price level. I do not say that stocks in this grouping should be completely avoided, but I do say that they should be minimized, particularly in the case of a professional man who is on his own. Where they are used as investment, they should be acquired only after a business readjustment has taken place and sold when adequate recognition seemingly has been given to foreseeable earnings and dividend prospects.

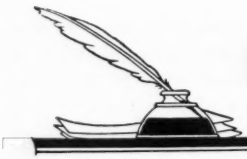
The third general grouping of common stocks is "growth" issues. Issues in this grouping are, by and large, the most desirable for long range equity investing. If equity investments are concentrated in stocks that show continued growth in sales, gross revenues and net income, they should not only tend to minimize risk but also show better than average capital enhancement.

Growth industries and growth companies are those showing a better rate of growth than the country as a whole. The chemical industry, for example, has grown at an average rate of approximately three times that of all American industry. Because of the necessity to expand, capital needs of companies in this common stock category are usually heavy and the percentage payout of earnings in the form of dividends is characteristically small. With present high income taxes, however, this is favorable to investors interested in long-range growth, since this compounding of earnings substantially enhances earnings, assets and accordingly future earning power. "Growth" issues tend to sell on a liberal price-earnings ratio, and therefore one should try to avoid paying a price which discounts too far into the future, the growth that may be attained.

It seems to me that the most favorable situated growth industries are basic chemical and chemical processing, natural gas, light metals (aluminum and titanium) and electronics.

COVER

PICTURED on this month's cover is the attractive swimming pool and its environs at Whitefield's Mountain View House. The annual meeting of the New Hampshire State Dental Society will be held in Whitefield June 12 to 14. For detailed information about the meeting, please address Doctor F. E. Williams, Secretary, New Hampshire State Dental Society, 814 Elm Street, Manchester, New Hampshire.



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

WHAT ARE THE CHANCES FOR SOCIAL SECURITY?

MORE THAN ever before dentists are expressing a vigor of action on the subject of OASI. They are writing to their Senators and Congressmen; they are organizing into groups to press for inclusion under the provisions of the Social Security Act. We may expect these militant men to have their voices heard by members of the House of Delegates of the American Dental Association before the San Francisco meeting in October.

A national group has been organized, the Congress of American Dentists for OASI. This is a coalescence of the groups that were first formed in the state and local dental societies. By mutual consent and unselfish action these local units came together to create a nationwide organization. The Congress of American Dentists for OASI represents a much needed rallying point to which dentists can go who wish to contribute their efforts and money to further the cause of OASI for dentists.

Heretofore a dentist who wished to be included under social security could express his wish to his Congressman or Senator. These lawmakers would in turn write a courteous letter in reply stating that the official position of the American Dental Association as expressed by several actions of the House of Delegates was against such inclusion. What these Congressmen did not know was that actions of the House of Delegates were at variance with the polls conducted among the *dues-paying members* of the American Dental Association.

Without exception every poll conducted by a state or local dental society, *component or constituent societies of the ADA*, has revealed overwhelming sentiment in favor of inclusion under OASI. A conservative figure would be that 75 per cent of the dentists who have voted in these polls have expressed sentiment *for coverage.*

The purpose of the Congress of American Dentists for OASI is to

make the result of these polls known to members of the U.S. Congress and to conduct polls in these states where the dental society officials have been reluctant, for a variety of reasons, to ask for an expression of sentiment from their members. The Congress of American Dentists expects in this way to accumulate a body of solid evidence that will represent the free and democratic expression of opinion from the majority of the dentists of the country. This kind of evidence will be incontrovertible and will represent an accurate opinion poll of the true sentiments of dentists.

Political realism requires us to see that when a member of the House of Representatives or the Senate is confronted with documentary evidence from his own constituents, as opposed to a vote by the House of Delegates of the American Dental Association, he is going to uphold the sentiments of the people who elected him. This suggests that despite what action is taken by the House of Delegates at the San Francisco meeting, the Congress of the United States will listen to the voices of the people back home, provided the voices are vigorous enough and that they speak in a tongue of authority based on evidence. The newly formed Congress of American Dentists for OASI will supply that vigor and that voice. Money, however, will be required to carry out the objectives.

For those dentists who wish to support the Congress of American Dentists for OASI by contributions or work, the officers are President, J. Garrett Reilly, 2401 North Capitol Street N.W., Washington, D.C.; Secretary, Earl S. Elman, 6350 North Clark Street, Chicago; Treasurer, Joseph S. Frost, 185 Noble Avenue, Crafton, Pittsburgh 5, Pennsylvania.

It must be clearly stated that the one single purpose of the Congress of American Dentists for OASI is to press for inclusion of dentists under the Social Security Act. When this objective is accomplished the group will disband and any money that is unspent will be given to the Relief Fund of the American Dental Association.

In a democratic society men may band themselves together for any worth-while objective. In this case it is a group of dentists who have expressed their democratic prerogative by organizing to support a measure that will affect their personal lives; a measure that more than 75 per cent of the dentists of the country appear to favor. There is little doubt of their success, provided they receive tangible support from the dentists of the country who have expressed their sentiments for inclusion under OASI.

Edward J. Ryan

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Oral Leukoplakia

Q.—A patient of mine has had oral leukoplakia for about three years. A heavy cigarette smoker, using two or three packs daily, he stopped smoking a year ago and also has refrained from eating hot and spicy foods. The oral condition improved immediately, but he still has some patches on the left dorsal and upper anterior parts of his tongue. These are not heavy and have thinned out considerably. He is averse to an operation and is self-conscious about his tongue, as well as fearing it might be pre-cancerous.—D.S.N., Maine.

A.—From many years experience in the practice of dentistry, I have seen literally hundreds of cases of oral leukoplakia. Of these, so far as I know, one, on the advice of the late Doctor Joseph C. Bloodgood, was successfully treated with radium. The other, in the mouth of a physician, was surgically removed about twenty years ago and has never recurred.

In a few of my cases, the patients have given up the use of tobacco, with, in some cases, the leukoplakia disappearing, and in other cases no improvement.

If the leukoplakia in your case is not verrucose in appearance, I would think, considering that the appearance has improved, that you can safely defer any local treatment unless the condition worsens. And, considering that your patient had the good sense to give up cigarettes and hot or spicy foods, I believe the danger of cancer developing is most remote. However, it is advised[1] in cases of doubt, to have a biopsy.—G. R. WARNER.

Procaine Complications

Q.—I have a woman patient about 45 years of age who has an upper left first molar to be extracted.

I injected one c.c. of procaine in the buccal side when the patient complained of severe headache in both occipital and frontal portions of her head. I massaged her neck, and within ten minutes the pain in that part had subsided. I then put cold towels on her forehead and exerted thumb pressure on her temples. In about fifteen minutes the pain had subsided, and the patient was again normal.

I refused to administer more anesthetic or remove the tooth until I could find some reason for her reaction. Can you help me in this case?—J.D., New Jersey.

A.—We have known several cases similar to this, one of which was in our practice within the last year, and we are convinced that the reaction was caused by the needle penetrating a blood vessel depositing the solution directly into the blood stream. We repeated the injection slowly and cautiously

[1]Keller, J. A. Junior; Finley, C. W.; Nabers, J. M.; Ritchey, Beryl; and Orban: Leukoplakia. JADA [November] 1954.

at a later sitting with normal satisfactory results.—V. C. SMEDLEY.

Paresthesia in Face

Q.—The patient, a woman about 60 years of age, complains of a feeling of numbness on the left side of the face, which first appeared about three weeks ago. This starts beneath the zygomatic bone, radiates to the midline, and extends to the lower border of the mandible.

The color of the patient's skin is normal, the face symmetrical, and movement of the muscles of the face and mouth normal.

She is wearing full upper and partial lower dentures made about five years ago. The remaining teeth appear normal roentgenographically, and there seems to have been no closure of the bite. Removing the dentures does not alter the condition.

At present her physician is giving her massive doses of vitamin B_{12}, but he is also at a loss as to the cause of the numbness in her face. Have you any suggestions?—I.F., New York.

A.—Your case of the patient with numbness of the left maxillary area is puzzling. You have discounted a Bell's palsy, and apparently there is no involvement of the fifth nerve.

The physician has probably ruled out a small intracranial hemorrhage, and I can hardly imagine one to result in the involvement of such a small area of the face.

There is the possibility of an involvement of the parotid gland, but I suspect you have ruled out that possibility.

Disturbance of the temporomandibular joint has never in my experience resulted in a paresthesia of the face such as you describe.

We have localized paresthesias from injury to a nerve trunk, but apparently that is not a possibility in your case.

So, I am at as much of a loss to account for the condition of your patient as yourself and the attending physician.—G. R. WARNER.

Night Grinding Habit

Q.—It seems I am always asking favors of you. This time it is regarding two of my patients who are wearing their teeth down rapidly. I have suggested they have an appliance made, which they can wear at night to avoid the possible chance they are gritting their teeth while they sleep.

What sort of appliance is used in such cases? Prize fighters and football players use a rubber or plastic guard, but I do not think this would relieve the condition.—S.O.S., Colorado.

A.—If your patients are grinding their teeth at night, they can be helped by wearing a splint covering all the teeth on either jaw. The occlusal surface of the splint should be smooth, and it can be made of acrylic.

We have found in some cases that wearing the splint at night for a few months has cured the patient of the night grinding habit.

In one article[2] the authors held that vulcanite or acrylic were too hard and had resulted or could result in traumatizing the teeth in the arch opposing the splint. The authors of this article found that Vinolin was the ideal material for

[2]Ingersoll, W. B. and Kirens, E. G.: A Treatment for Excessive Occlusal Trauma or Bruxism, JADA [January] 1952.

a splint to treat the night grinding habit.—G. R. WARNER.

Saliva Seepage From Mouth

Q.—I have a denture patient who complains of saliva seeping out of the corners of his mouth. This man has worn dentures for about fifteen years and has noticed this for the past five years.

I would surely appreciate knowing what the cause of this might be and whether or not there is a treatment.—A.G.P., Illinois.

A.—The seeping of saliva at the corners of the mouth can be prevented by supplying the patient with new dentures opening the bite somewhat, and by increasing the buccal contour on the upper denture to support the sagging cheek muscles and lessen the depth of the wrinkles at the corner of the mouth.—V. C. SMEDLEY.

Burning and Metallic Taste

Q.—I have a denture patient who has me confused. Two years ago I extracted her teeth and made her upper and lower dentures of acrylic. (She went without teeth for three months in the interim.) The dentures seem to fit and function all right, but she complains that after having the dentures in place for a short time, her tongue and lips have an annoying, puckery feeling, and she has a metallic taste in her mouth. The mucous membrane under her dentures is not inflamed, and there is no soreness. She is in good health, but her physician prescribed a tablet that contains iron, phosphorus, and calcium. I have suggested to her that she stop taking these tablets for a month to see if it makes any difference.

My patient visited her sister who lives in a neighboring city, which uses well water in its city mains. She thought her mouth felt better while there, so I suggested that she stop using our city water for drinking and cooking purposes, using spring water from the country.

She had some complaint when she first received her dentures, but I had not seen her for a long time until two weeks ago when I learned of her difficulties. She went to another dentist and he gave a patch test with acrylic, which was negative.

I want to do anything that will help this patient, but I just do not know what to do. I wonder sometimes if her discomfort is imaginary, although I have never suggested that to her. Any help you can give me will be appreciated.—H.D.G., Pennsylvania.

A.—Was the acrylic used in these dentures one of the brands approved by the ADA Council on Dental Research? And are you sure that the dentures were thoroughly polymerized during the curing process? If so, I think it is safe to assume that the material is not the cause of the burning and metallic taste sensations. And I believe she will accommodate her tissue to these dentures if she will persist in wearing them, taking them out only at brief intervals to rest her mouth.—V. C. SMEDLEY.

Gingivitis

Q.—Saturday a young college student came into my office because he was having trouble with his "gums" bleeding. He has a clean, well-cared-for mouth. I cleaned his teeth and treated his "gums," but did not think this would stop his bleeding. I also restored one deciduous tooth. He has two deciduous teeth with no permanent bicuspids under them. He also has one deciduous molar that has been removed and re-

placed with a removable appliance. He has an overbite, which is causing some wear, especially on lingual surface of upper incisors, but not enough to cause trauma to the "gums." In other words, his mouth is in too good shape to cause this disorder, and I am afraid there might be some systemic cause. This is Sunday morning and he has gone back, so I did not have much time to observe him. He has had this condition for some time, probably about six months.

I suggested a thorough physical check-up. He is a large, husky, healthy fellow and does not look like there could be anything wrong with him.—F.N., Kansas.

A.—A mild gingivitis in which there is not much hypertrophy, but a good deal of bleeding, is not uncommon in teen-age patients. If, in such a case, a complete physical examination, including blood chemistry as well as a blood count, does not uncover any systemic cause for the bleeding, I treat it as a local condition, except I do see that there is a good natural vitamin C intake. If, in such a case, a thorough prophylaxis is given at least every three months and the home care is meticulous, the bleeding should gradually decrease. However, there are some people in whose mouths there is always some bleeding during a prophylactic treatment, despite apparently good home care and a record of good general health.—G. R. WARNER.

Loss of Temporary Central

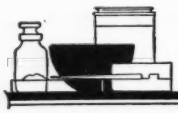
Q.—A child, two years old, with upper left central missing and mouth full of blood, was brought to my office yesterday by one of the parents.

After the patient was quieted, the parent told me how the little fellow fell down and knocked out the temporary central tooth. It came out clean, root and crown. Now the parents are much disturbed, as the child will have an open space there until the permanent central eruption when he is about six or seven years of age.

I personally cannot see how I can make a replacement in such a small child as he is at present.

Have you any suggestions as to what should be done at this stage? Would appreciate a reply.—D.C.B., Massachusetts.

A.—There is nothing you can do about the loss of the deciduous maxillary central incisor for your two-year-old patient. Fortunately, there is not much tendency for the space caused by the loss of a maxillary incisor to close if the occlusion is normal. However, if contrary to the usual behavior in such cases, the space in this child's mouth is closing as he approaches the age for the eruption of the permanent incisor, you can band the tooth either side of it and solder a wire or a tooth between the bands, and thus hold the space until the permanent incisor has erupted far enough to hold the space for itself. —G. R. WARNER.



TECHNIQUE of the Month

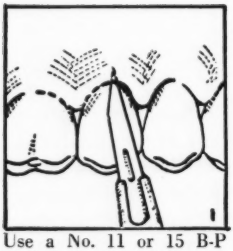
Originated by W. EARLE CRAIG, D.D.S.

Surgical Removal of Alveolar Process Without Using Mucoperiosteal Flap

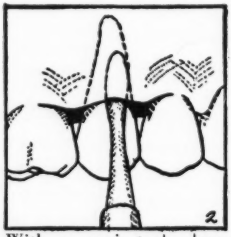
BY LOUIS SCHWARTZ, D.D.S.

and HERMAN MEYERS, D.D.S.

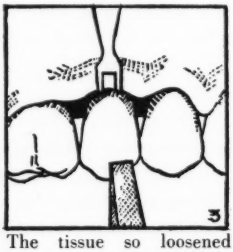
Drawings by Dorothy Sterling



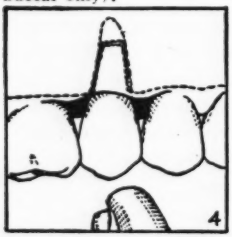
Use a No. 11 or 15 B-P blade to incise the interseptal tissue and free the tissue from around the neck of the tooth to be extracted. Continue loosening the tissue to the median line of adjacent teeth (on the buccal only).



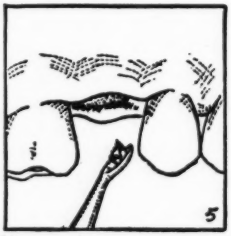
With a periosteal elevator, reflect the interseptal tissue and detach the mucoperiosteum from the buccal plate of bone covering the root of the tooth.



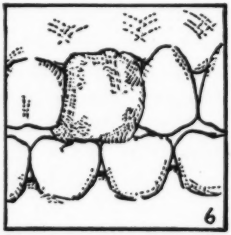
The tissue so loosened forms a pocket which, when held with a tissue retractor, permits chisel and mallet to be used to remove the bone from the buccal of the root.



The tooth may now be extracted easily with a forceps.



Use a curette to remove bone chips from the socket.



Place a sponge over the alveolus for pressure. Suturing is not usually necessary; tissues position themselves naturally.

DENTAL POLITICS

WHAT TYPE of person enters dental politics? Usually men who have made a success of their own dental practice and are looking for other fields to conquer. Because of enthusiasm for their professions and financial success, these individuals feel that they do not care to stagnate in their offices and would like to broaden their scope of interest. The prime motivating factor is usually the deep conviction that they are capable, in a small way, of contributing to the maintenance of the high professional standards of dentistry. This type of dentist usually willingly accepts any position given him, does a good job, and expects little personal glory. He serves on committees, attends meetings, and after many years of service accepts high office if offered. He does not seek a high office but accepts it as a reward for his many years of service to the profession.

On the other hand, there are persons who enter dental politics with strict personal acclaim as their motive and are out for all the glory they can get. They want their name known by everyone and usually do not care how they do it. They are dissenters and trouble makers, disrupting the honest efforts of others, and usually making fools of themselves. They want the best positions and the high offices without the preliminary training necessary. They are the same as weeds in a wheat field, or thorns on a rose bush. Usually being thick-skinned, they are hard to insult, but constant reversals and reprimands will eventually soak into their distorted brains the fact that they are not wanted and are emphatically a discredit to dentistry.

A word or two about dental political parties. Any one group consistently in control of an organization tends to weaken the structure and removes the competitive spirit of achievement. It is natural for one group to think that they can do a better job than the one in power, and if they can elect officers, then they can try to prove it. As long as it is impossible for any one party to remain in the driver's seat for long, their actions on society matters must be beyond reproach. Since dentistry has a limited scope, its members should be friendly and cordial, regardless of their political affiliations. Remember, it is easy to make a political enemy.

Dental politics is unique in many ways, regardless of whether it is on the national, state or local level. Without financial reward, thousands of dentists are engaged in society affairs, spending many hours as well as many of their own dollars to better the profession. We must be ever vigilant that our leaders be men of sterling character. The days ahead for dentistry look rough, and if we are to continue the splendid progress made, we must have only the best of dental leaders. Encourage

the younger members to take an active part in their society affairs. Try giving a little, not just taking. Remember always that dentistry has been good to us—let us be good to dentistry.—*The Fortnightly Review of the Chicago Dental Society.*

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ CXXIX

(See page 731 for questions)

1. (a) or (c). (Blair, V. P.; and Ivy, R. H.: Essentials of Oral Surgery, Ed. 4, St. Louis, The C. V. Mosby Company, 1951, page 245)
2. True. (Sarnat, B. G.; and Schour, Isaac: Oral and Facial Cancer, Chicago, The Year Book Publishers, 1950, page 160)
3. (b) second bicuspid. (Sicher, Harry: Oral Anatomy, St. Louis, The C. V. Mosby Company, 1949, page 390)
4. It is difficult and, in many cases, impossible to establish a favorable seat in the final impression. (Lewis, E. T.: Classification and Correction of Mandible for Full Denture Prosthesis, DENTAL DIGEST **58**:101 [March] 1952)
5. (b) unstrained. (Schweitzer, J. M.: Oral Rehabilitation, St. Louis, The C. V. Mosby Company, 1951, page 497)
6. Yes. (Accepted Dental Remedies, Ed. 19, American Dental Association, 1954, page 91)
7. (a) greater. (Nelson, B. A.: Rational Timing of Orthodontic Treatment, JADA **47**:141 [August] 1953)
8. (a) sealing. (Simon, W. J.: Fundamental Differences Between Amalgam and Inlay Preparation, JADA **42**:310 [March] 1950)
9. True. (Symposium: Sugar and Dental Caries: The Effect on the Teeth of Sweetened Beverages and Other Sugar-Controlling Substances, JADA **47**:414 [October] 1953)
10. (a) seldom. (Kanterman, C. B.: When Baby is Teething, ORAL HYGIENE **44**:185 [February] 1954)

U. S. PUBLIC HEALTH OFFICERS LOSE MILITARY STATUS

BECAUSE CONGRESS deleted one section of a bill, U.S. Public Health Service commissioned officers no longer find themselves on "military status." Dentists, researchers, and others in professional categories, as well as physicians, are affected. Unless and until the Congress passes new legislation, these persons will be denied the following benefits which all PHS commissioned officers have received since 1945: allowances for purchase of uniforms; survivors and death payments, similar to those granted military personnel; and all other military benefits not specifically provided by law under the Public Health Service Act.

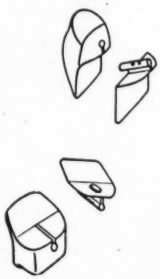
—*Journal of the American Medical Association.*





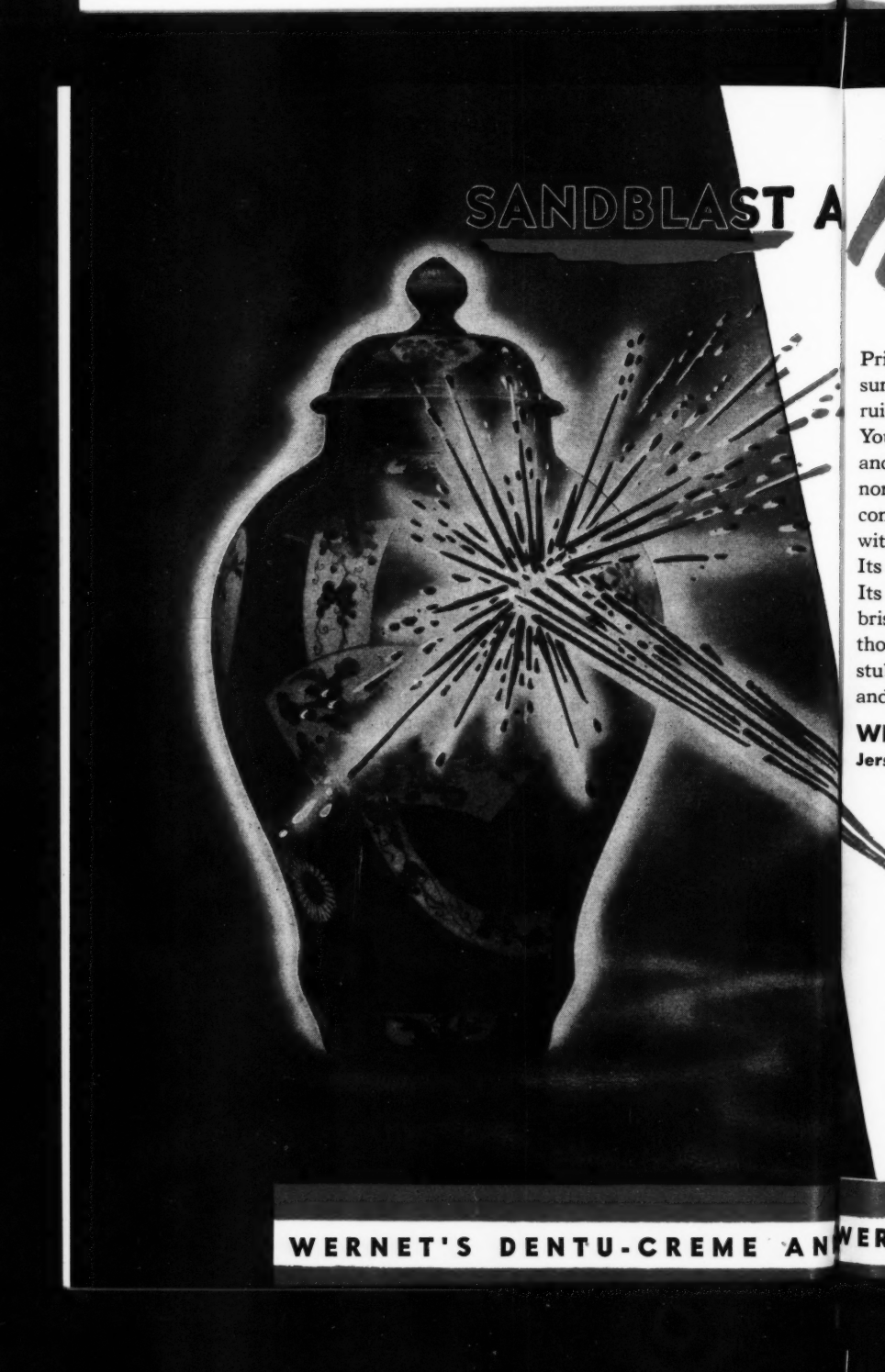
FROM WHERE WE SIT, there appears to be a swing toward more *fixed bridges*. It's a good trend. For where mouth conditions permit, there is no restoration that compares with a fixed bridge.

And may we suggest that in fixed bridgework *Trupontic teeth* (anterior or posterior) provide advantages *not* obtained with any other type of tooth. More comfortable . . . More sanitary. Ideally suited to the newer technics; and the only tooth *completely* suited to fixed bridge immediate-extraction cases.



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Priceless ancient pottery calls for careful cleaning, lest the beautiful surface finish be irreparably damaged. • Beautiful dentures, too, can be ruined by the careless use of inappropriate cleansing agents. You can help protect them by suggesting Wernet's Dentu-Creme and Wernet's Denture Brush. • Dentu-Creme is smooth, absolutely non-injurious, and an excellent detergent. The special polishing agent it contains makes it ideal for use on acrylics. • Wernet's Denture Brush, with the Easy Grip Handle, conforms to professional specifications. Its divided tufts of fine bristles are individually wired-in for long life. Its black bristle section is used on the ridge and the vault—its white bristle section on the teeth and interproximal surfaces. • For safe, yet thorough removal of mucin plaques, food particles and stubborn stains, suggest Wernet's Denture Brush and Wernet's Dentu-Creme.

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WERNET'S DENTURE BRUSH



LAFFODONTIA

Sam: "Did you hear of the awful fright Jim got on his wedding day?"

Fred: "Yes, I was at the church. I saw her."

★

He: "Gosh, but you've got a lot of rouge on your lips!"

She: "Give me time, big boy. I've just arrived at this party."

★

A young couple had just returned to camp from a honeymoon trip. The camp matron immediately called on her.

"How did John register at that big hotel?" asked one of the dear girls by way of making conversation.

"Oh, just fine," replied the bride blithely.

★

Milton Smith had drowned in the river, and a policeman was sent to his home to break the news to his wife.

"Don't scare her to death," his superior officer warned.

So the officer wended his way to the Smith home and knocked on the door. When Mrs. Smith answered the summons the visitor said:

"Is this where Widow Smith lives?"

"I am Mrs. Smith, but I'm not a widow."

And the caller said simply, "What will you bet?"

★

Mrs. Smith (at the bridge party): "Before we start playing, do you mind if I consult my husband on a point I'm not quite sure of?"

Host: "Oh, certainly not, my dear."

Mrs. Smith (turning to her husband, in a whisper): "Well, George, did you say two kicks or three, for 'no trumps'?"

The boy and girl were out in the highway when the car broke down. He didn't seem to mind and wanted to make love. "My kisses will put new life in you," he said.

"Then for goodness sake get out and kiss the car," she replied sweetly.

★

Suitor: "Honey, don't you think you could manage to live on twenty-five dollars a week?"

Girl Friend: "Get the license. I'll try it a week."

★

Grocer: "You were gone longer on your auto trip than you expected."

Customer: "Yes, it took an extra week to fold up the road maps."

★

Warden: "What made you beat up your cell-mate the way you did?

Convict: "Aw, dat guy gits wise wit me."

Warden: "What's he done now?"

Convict: "Tore da leaf off da calendar and it was my toin."

★

Hubby: "On my trip to South America I saw a lot of beautiful panoramas."

Wifey: "I thought you promised me you wouldn't run around with those native girls!"

★

Which leads us to say: Kissing may be dangerous as we are warned, but we are positively not a nation of cowards.

★

Mr. Softy: "You know, I am very fond of birds. Yesterday one sweet little thing actually settled on my head."

Mr. Tuffguy: "It must have been a woodpecker."

THE *NEW* REPLICA FILLING MATERIAL INTRODUCED TO THE PROFESSION IN AUGUST 1954 HAS 3 PROVEN ADVANTAGES OVER PREVIOUS PLASTIC FILLING FORMULATIONS

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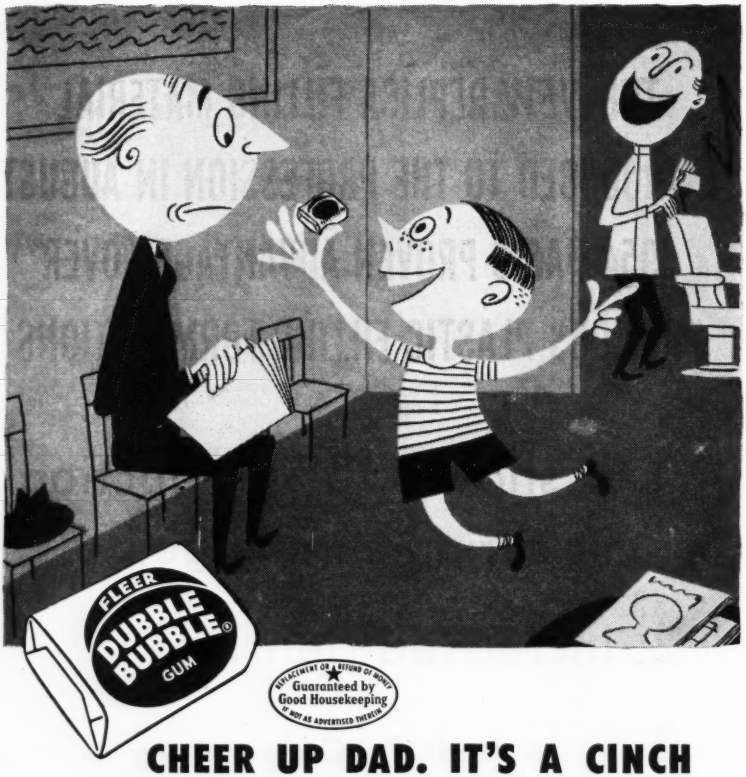
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EAST NEWARK, NEW JERSEY
PHONE: HARRISON 6-8570

April 25, 1955

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Aristaloy develops a crushing strength of 51,000 pounds per square inch and has an exceptionally low plastic flow of 1.4% to 1.8%.

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Aristaloy is a blend of selected sizes of deliberately shaped solid particles free from dust. It packs into a very dense filling which permanently seals the cavity.

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THERE IS STILL ONLY ONE ARISTALOY. It is practically zinc free, containing a beneficial 0.4%. It remains bright and clean in the mouth.

Insist on obtaining an Aristaloy dispenser combination from your dealer on your initial order.

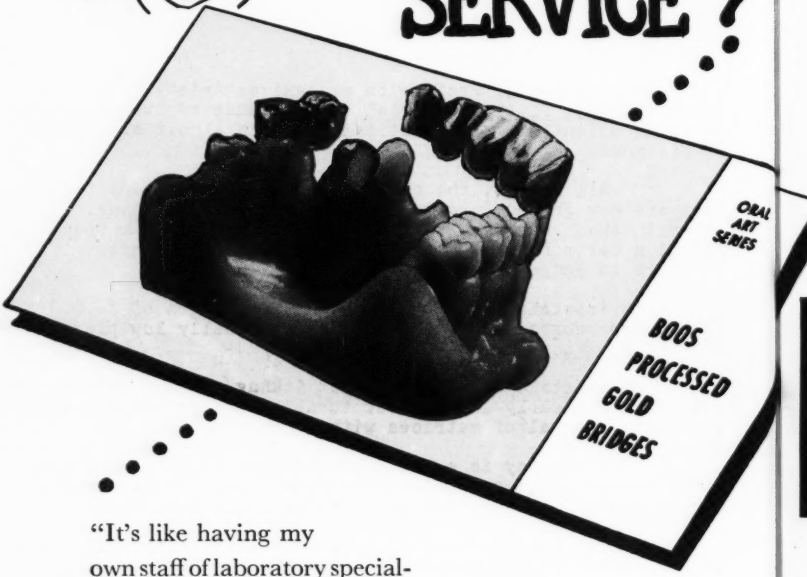
Sincerely yours,

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ENGELHARD



Why do I use BOOS SERVICE?



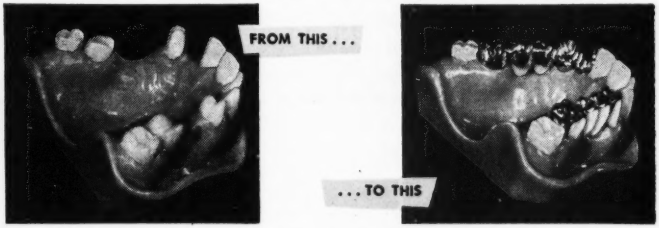
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Each case that comes to Boos, gets the individual attention of specialists skilled in the planning and construction of that particular type of restoration. That's why dentists everywhere are finding more and more reasons for sending their cases to Boos.

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. . . IN ONLY *TWO* SITTINGS

More and more dentists are turning to the Indirect Hydrocolloid Technique to save many hours of unproductive chair time in the construction of their inlays, crowns and bridges. And they are looking to Boos skilled technicians for results in their finished restorations that meet the high standards of their preparatory work.

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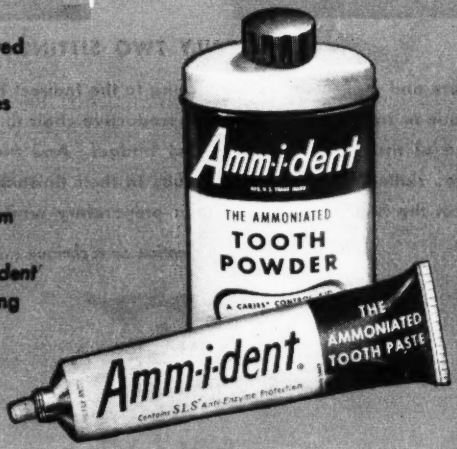
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- Urea penetrates to tooth pulp; *diffuses outward* as needed to maintain tooth and plaque above decalcifying level of pH 5.5 for 12 hours.

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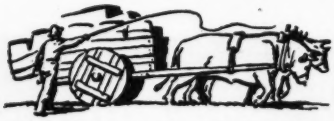


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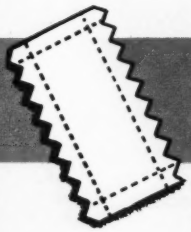
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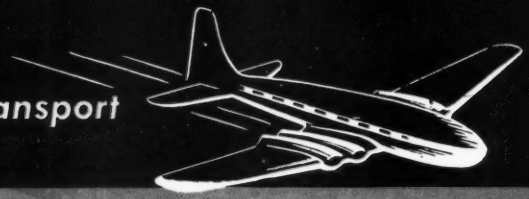
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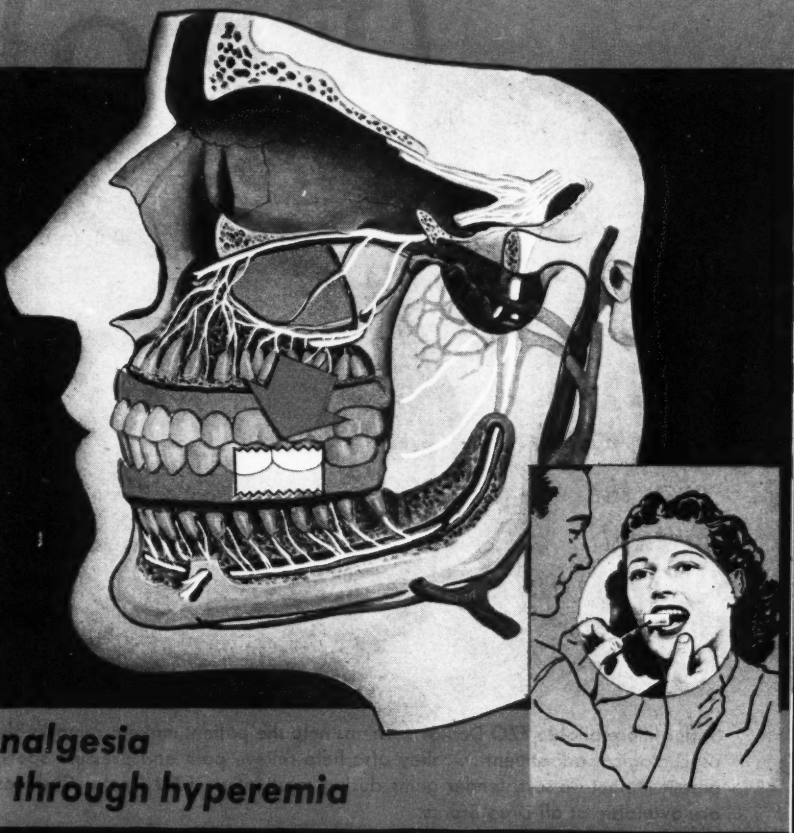
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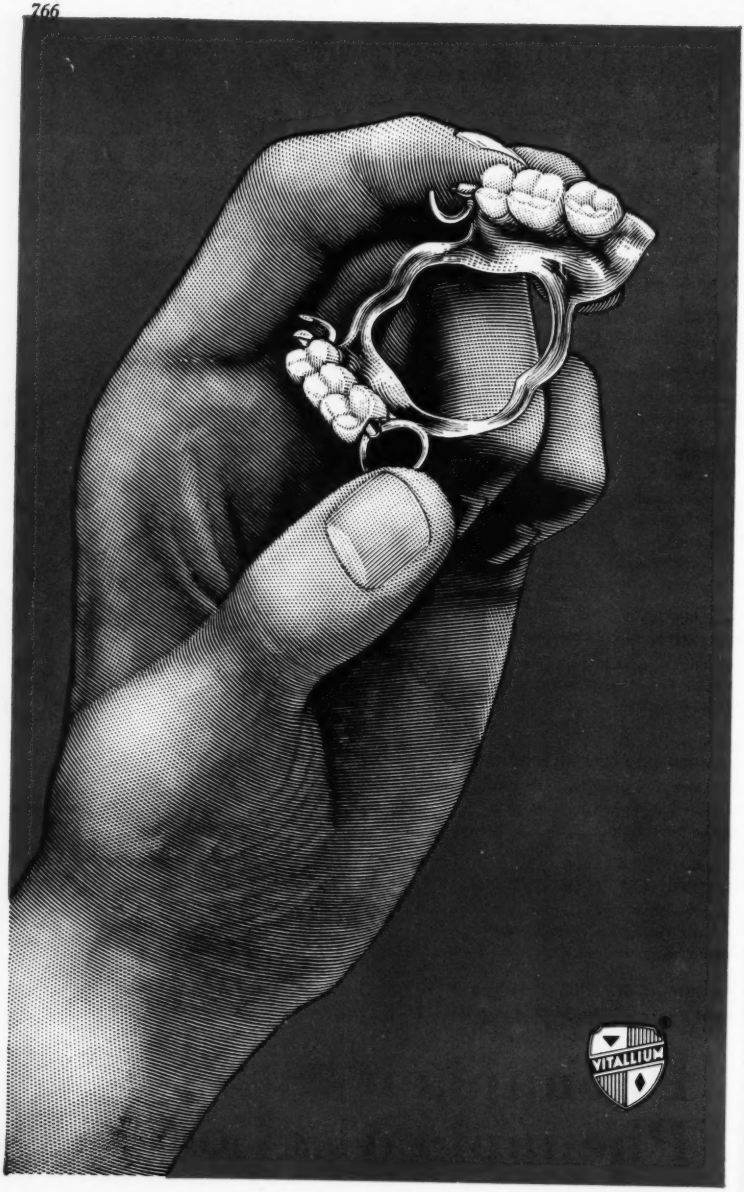
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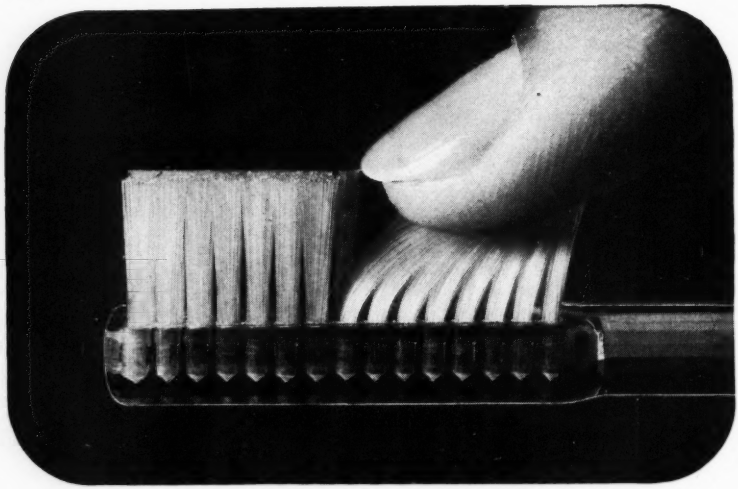
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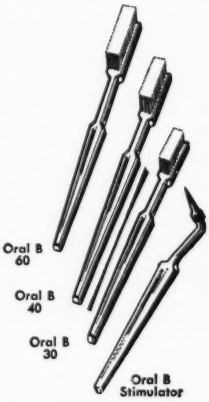
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Professional men generally agree that, regardless of the dentifrice used, a toothbrush is the most important factor in maintaining good oral hygiene.

Since dentists are unquestionably the most qualified persons to select the proper type of brush, the wisest people take their advice on this matter. In this way the best brush is chosen to fit each patient's needs.

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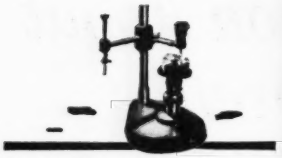


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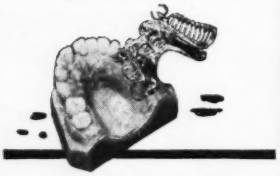
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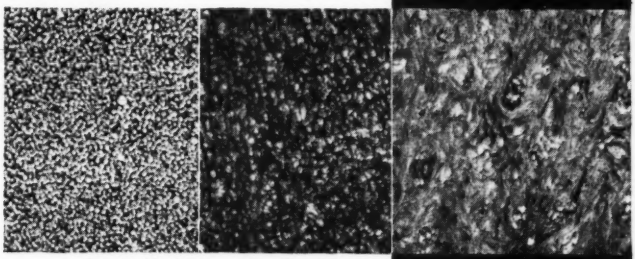
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Here's the new professional packing for Kleenex*, the only tissue that pops up, serves just one at a time. It's a pure white box that's designed especially for the use and convenience of dentists. And it's available in an easy-to-store case of 24 boxes. Keep Kleenex handy—for dozens of office uses!

Regular size No. 5101, 9" x 10".
Professional size No. 5405, 15" x 18"

Order through your supply dealer

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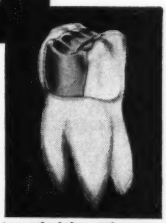
Goldsmith INLAY INLAY Golds



GB INLAY No. 1 for gingival or one surface inlays where occlusal stress is not a factor. Soft Type "A" $2.13 dwt. list.



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220 West 42nd St., New York

GOLDSMITH BROS. DENTAL CO.
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NOW! Formulated to reduce the burning sensation

Rebasing is done directly in the mouth, without the use of a Cellophane Barrier. Reline becomes an integral part of the denture with Lang Rebase Acrylic. This liquid is formulated to reduce the burning sensation. Lang Rebase comes in Light, Medium Dark Pink, and Clear, in 20 Reline Packages.

Lang's

SELF-CURING

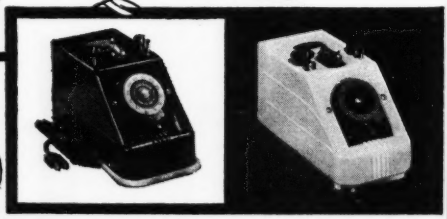
REBASE ACRYLIC

Lang Dental Manufacturing Co., Chicago 13, Ill.

There's NOTHING like the WIG-L-BUG© to Mix Alloy



• Uniformly! • Scientifically! • Quickly!



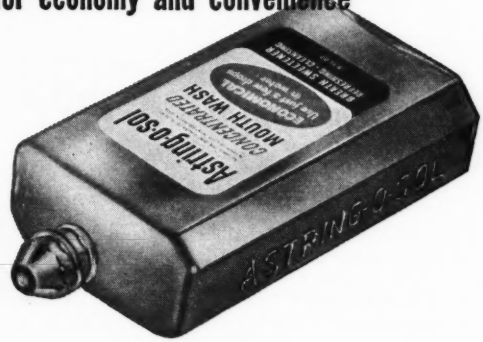
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CRESCENT DENTAL MFG. CO.
1839 S. Pulaski Road, Chicago 23, Illinois

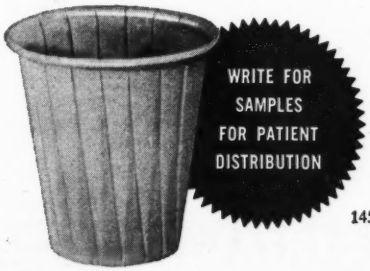
Astring-o-sol mouthwash

concentrated for economy and convenience



a little goes a long way

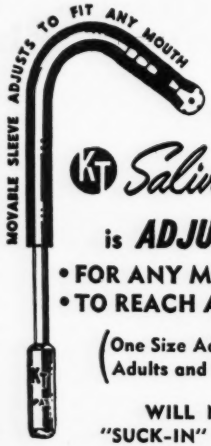
- Here is a peppy, invigorating mouth rinse that not only tastes good and sweetens the breath, but also helps loosen and flush away organic debris.
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- It's economical . . . it takes only a few drops of concentrated Astring-o-sol in a half-glass of water for a pleasing and effective mouthwash.
- USE IT AT THE CHAIR BEFORE AND AFTER DENTAL PROCEDURES
- RECOMMEND IT TO YOUR PATIENTS FOR DAILY MOUTH CARE



Remember... it takes only drops instead of drams because it's concentrated.

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1450 Broadway, New York 18, N. Y.

KT TIME SAVERS



only the KT *Saliva Ejector* is **ADJUSTABLE**

- **FOR ANY MOUTH**
- **TO REACH ANY AREA**

(One Size Adjusts For Adults and Children.)

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since infancy caused this 4 year old's malocclusion.



THUM
TRADE MARK

THUM broke the habit and teeth returned to normal position in 9 months.



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WONDRPAK SURGICAL CEMENT

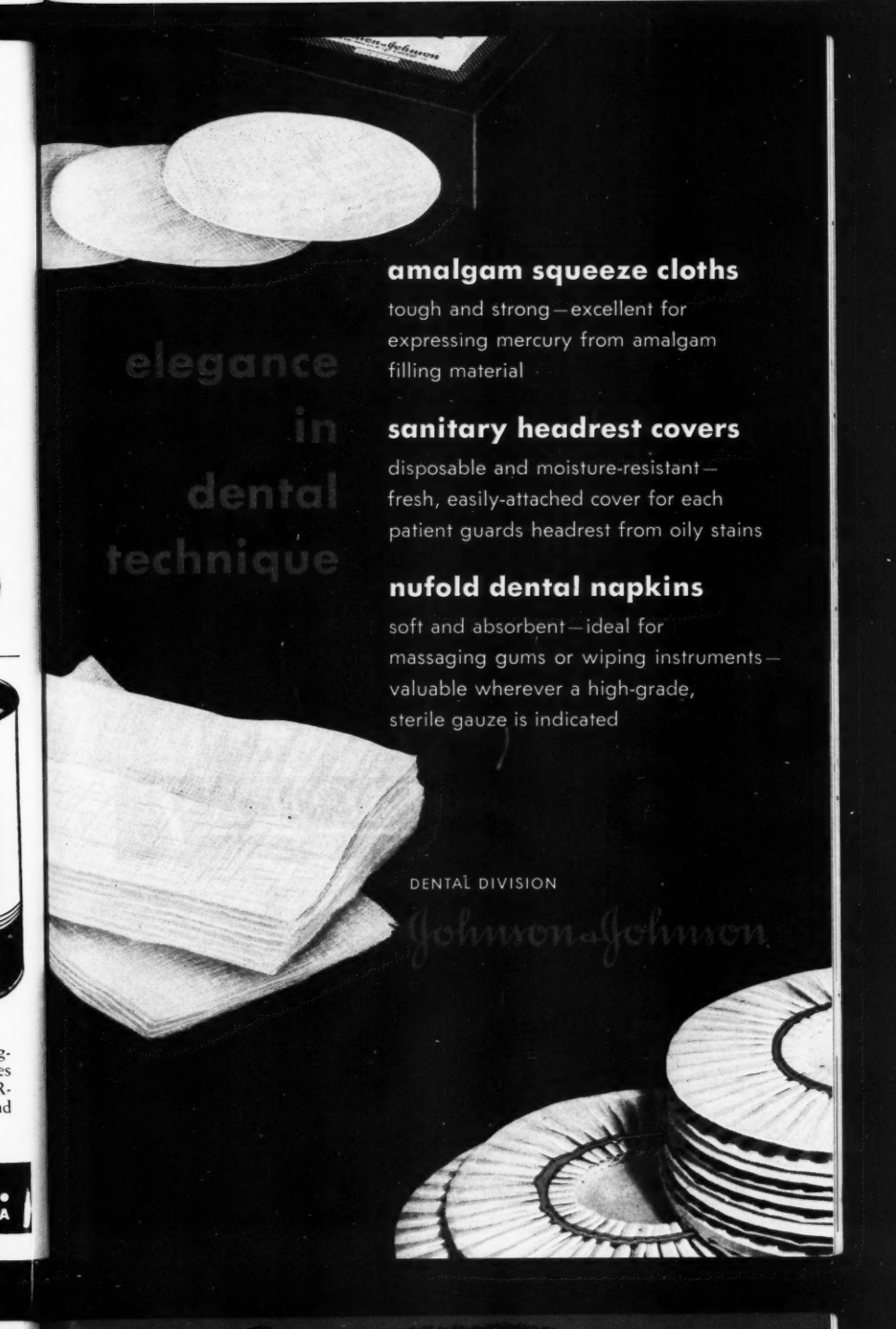


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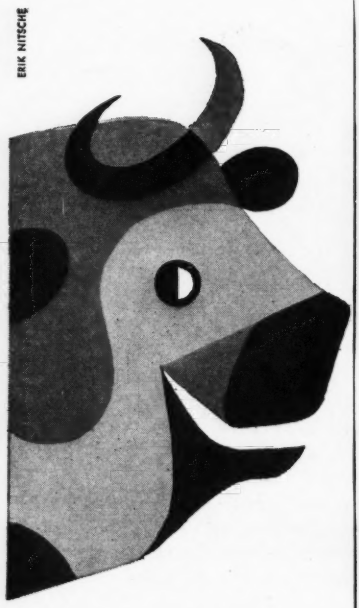
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a good beef

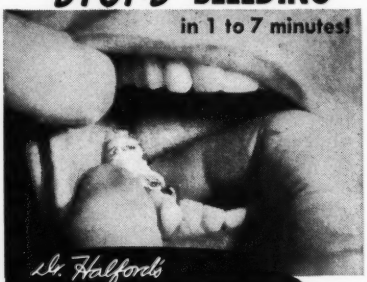
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that prevents breakage

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Since 1920 — mouth proved

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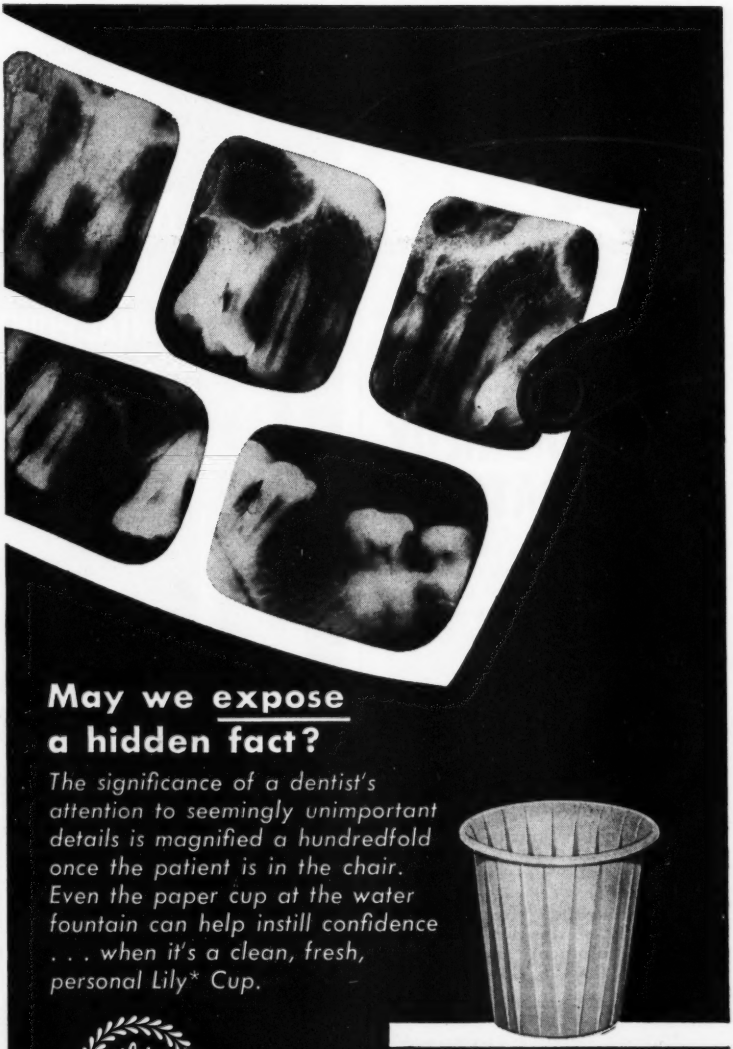
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The significance of a dentist's attention to seemingly unimportant details is magnified a hundredfold once the patient is in the chair. Even the paper cup at the water fountain can help instill confidence . . . when it's a clean, fresh, personal Lily Cup.*

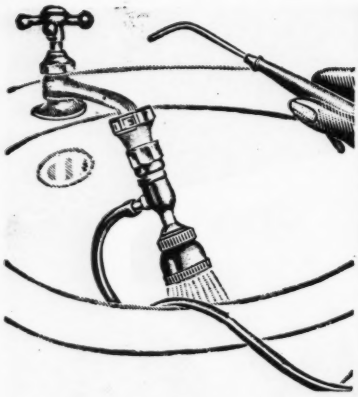
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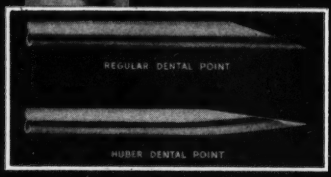
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for smoother, more accurate injections-

This new needle possesses a long 7½° bevel with the point located on central axis of the shaft. This point is right where it should be to assure straight insertion. It penetrates more smoothly with less effort and is far more comfortable for patients.

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Dispensed in 15cc polyethylene squeeze bottles; available at leading dental supply houses.



Accepted Council on Dental Therapeutics American Dental Association

ROWER DENTAL MFG. CORP. Boston 16, Mass. U.S.A.

Group A Classification announced J.A.D.A. 50:334 (Mar.) 1955

*Also available at dental supply houses; PULPDENT (Rower) PASTE (Brand of Calcium Hydroxide Paste), especially suitable in vital pulpotomy and in pulp capping.

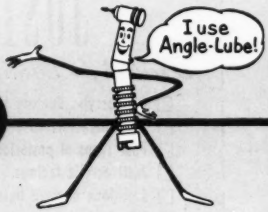
RPD-551A

These Products keep me at P.O.E.*



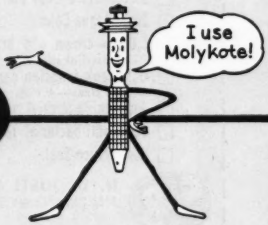
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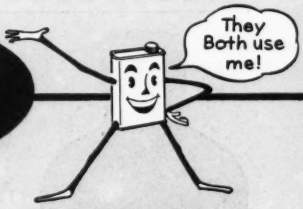
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Proven best for straight handpieces. 70% molybdenum disulphide. Works by impregnating bearing surfaces. Lets you boil, autoclave or cold sterilize without impairment of lubricity. $1.50 per tube



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A new specially developed, highly efficient cleaner. Fast-drying, non-toxic, leaves no film. $2.00 1 pt. can





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And Here's How it's Done

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STRAIGHT HANDPIECES

DAILY

1. Disassemble
2. Clean in **Instrument Cleaner**
3. Reassemble

WEEKLY

1. Disassemble
2. Clean in **Instrument Cleaner**
3. Reassemble and Molykote
4. Run to impregnate
5. Disassemble and wash again in **Instrument Cleaner** to remove excess **Molykote.**

CONTRA ANGLES

DAILY

1. Disassemble
2. Wash in **Instrument Cleaner**
3. Apply **Angle-Lube** to exposed gears and reassemble.
4. Run for minute or so to disperse **Angle-Lube**
5. Wipe off excess **Angle-Lube**

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*Peak Operating Efficiency

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BOSWORTH Improved SALIVA EJECTOR

for HIGH-SPEED TECHNICS

"Carries water away as fast as it can be poured in"



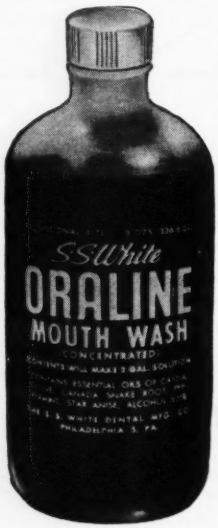
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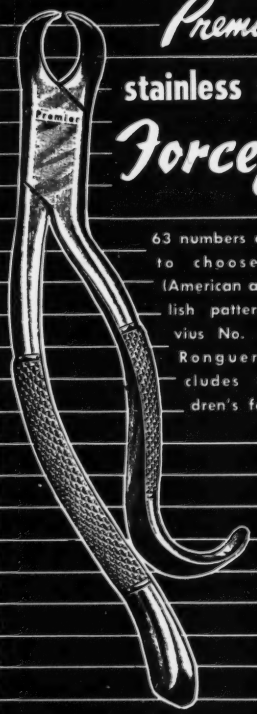
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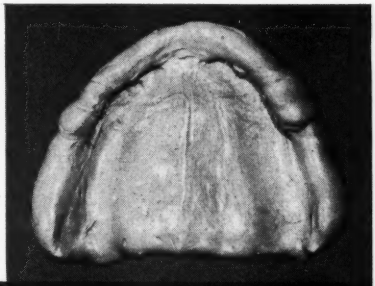
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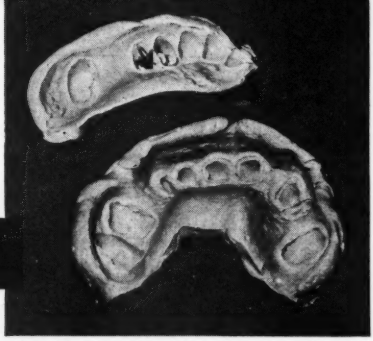
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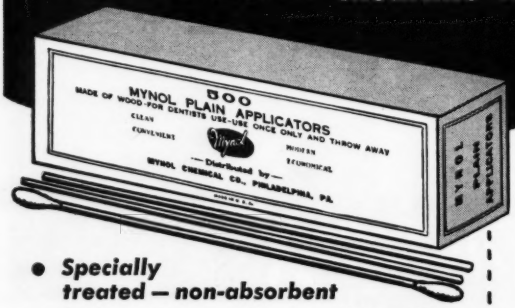
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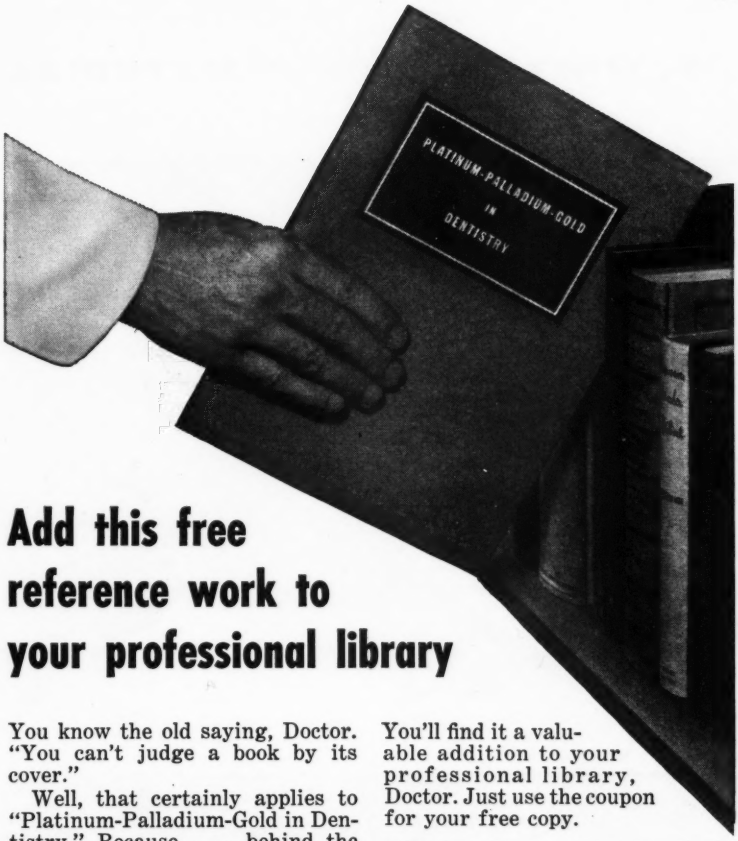
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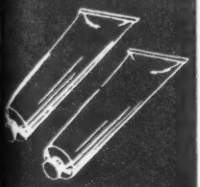
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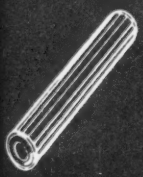
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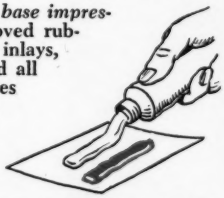
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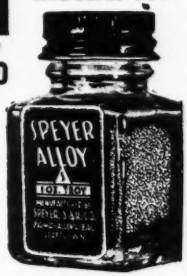
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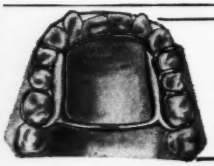
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with dual therapy of

VERDESOL
and
VERDESALVE

SURGERY: Before surgery, cleanse by spraying or irrigating gingival areas with VERDESOL. Repeated home use of VERDESOL *before* surgery, reduces pathogenic bacteria commonly found in the oral cavity.

During surgery, VERDESALVE is placed inside bone or soft tissue cavities formed by removal of impacted teeth, cysts, tumors and aberrant alveolar bone. Suturing VERDESALVE in the wound is advisable. It is completely absorbable—no residue will remain.

After surgery, continued home use of VERDESOL, held in the surgical areas, is suggested. It eliminates the taste and odor.

The healing properties of VERDESOL and VERDESALVE make this dual therapy a valuable adjunct to professional treatment of Oral Infections, Dry Sockets, Denture Irritation, Canker Sores. It is highly recommended for use with Immediate Dentures.

Order from your Dental Dealer.

Write for Literature and Case Histories.

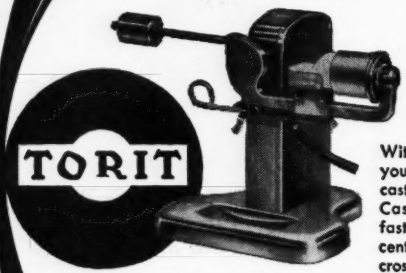
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CENTRI-VAC

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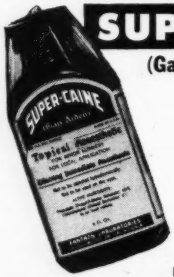


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With or without vacuum, you get more intricate castings because the Torit Casting Machine starts faster. And the vertical, centrifugal motion of the cross-arm provides direct, positive gold flow, eliminating spilling and providing excellent castings. *With* vacuum operating, the results are unexcelled for detail, feather edges and density.

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(Gan-Aiden) TOPICAL ANESTHETIC

- FAST ANESTHETIC ACTION
- DEEP PENETRATION
- NO NEEDLE PUNCTURE PAIN
- NO PAINFUL INSTRUMENTATION DURING SCALING OF TEETH
- REDUCES PATIENT'S FEAR

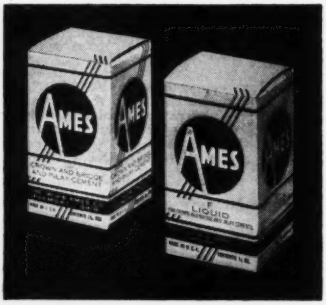


- Super-Caine Ointment for Post Extraction Pain.
- Prevents Dry Sockets.
- Promotes Healing.
- For Use with New Dentures.
- Relieves Sore Spots.

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Complete ( )
Partial ( )
Upper ( )
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Patient.....
Dentures inserted (date).....
Reexamination (date).....
Abrasion.....
Discoloration.....
General Condition.....
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Six months after insertion, would they still gleam with their original lustre . . . still retain all their meticulously molded ridges?

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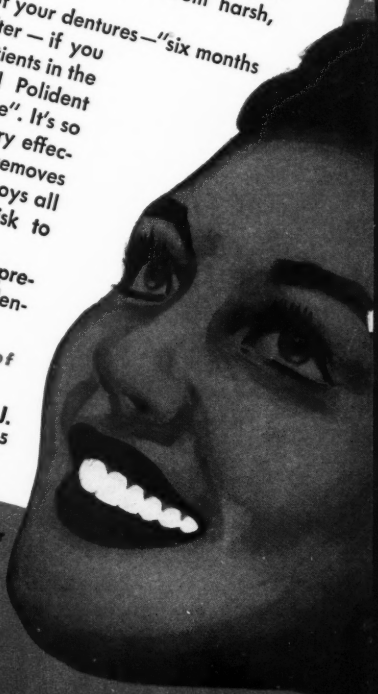
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